

MEDICARE

PART B



Modifiers Billing Guide June 2009

NHIC, Corp.

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INTRODUCTION

The Provider Education and Outreach Team at NHIC, Corp. developed this guide to provide you with Medicare Part B *Modifier Billing Guide* billing information. It is intended to serve as a useful supplement to other manuals published by NHIC, and not 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 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, *Medicare B Resource* (quarterly provider newsletter), and special program mailings, provides 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; and Publication 100-4, Chapter 23 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/>

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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 INFORMATION

The use of modifiers is an important part of coding and billing for health care services. Modifier use has increased as various commercial payers, who in the past did not incorporate modifiers into their reimbursement protocol, recognize and accept HCPCS codes appended with these specialized billing flags.

Correct modifier use is also an important part of avoiding fraud and abuse or noncompliance issues, especially in coding and billing processes involving the federal and state governments. Several of the top billing errors involve the incorrect use of modifiers.

WHAT ARE HCPCS MODIFIERS?

A modifier is a two-digit numeric or alpha numeric character reported with a HCPCS code, when appropriate.

Modifiers are designed to give Medicare and commercial payers additional information needed to process a claim. This includes HCPCS Level 1 (CPT) and HCPCS Level II codes.

A modifier provides the means by which a physician can report or indicate that a service or procedure that has been performed has been altered by some special circumstances(s), but has not changed in its definition or code. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities. These codes should be entered in item 24D on the Form CMS-1500 or LOOP 2400 SEGMENT SV101.

Some examples of when a modifier may be appropriate include:

- A service or procedure has both a professional and technical component, but both components are not applicable.
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure has been increased or decreased in complexity or performance.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- Unusual events occurred during a procedure or service.

Placement of a modifier after a CPT or HCPCS code does not insure reimbursement. A special report may be necessary if the service is rarely provided, unusual, variable or new. The special report should contain pertinent information and adequate definition of the procedure or service performed that supports the use of the assigned modifier. If the service is not documented, or the special circumstance is not indicated, it is not considered appropriate to report the modifier. A report should not be submitted unless requested.

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Some modifiers are informational only (e.g., -24 and -25) and do not affect reimbursement. They can however, determine if the service will be covered or denied.

Other modifiers such as modifier -22 (unusual procedural services) will increase the reimbursement and protocol for many third-party payers if documentation supports the use of this modifier. Modifier -52 (reduced services) will usually equate to a reduction in payment.

There will be times when the coding and modifier information issued by CMS differs from the AMA's coding advice in the CPT manual regarding the use of modifiers. A clear understanding of Medicare's rules is necessary in order to assign the modifier correctly. It is the responsibility of each provider or practitioner submitting claims to keep abreast of the Medicare program requirements.

AMBULANCE

Origin And Destination Modifiers

Two single digit modifiers **must** be used with ambulance service codes to identify both the point of origin and the destination. The first single digit modifier indicates the point of origin. The second single digit modifier indicates the destination.

These single digit modifiers are defined as follows:

Modifier	Description
D	Diagnostic or therapeutic site other than "P" or "H" (includes free-standing facilities)
E	Residential, domiciliary, custodial facility (includes non-participating facilities)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital (includes OPD or ER)
I	Site of Transfer (e.g., airport or helicopter pad) between modes of ambulance transfer
J	Non hospital-based dialysis facility (free standing)
N	Skilled Nursing Facility (Medicare participating only)
P	Physician's Office
R	Residence
S	Scene of accident or acute event
X	Immediate stop at physician's office on the way to the hospital (destination only)

Note: Modifier E applies to Assisted Living and Nursing Facilities

****To avoid denial of lines of service please enter origin/destination modifiers on all lines of the claim.**

This especially helps when round trips or two trips in one day occur. Each trip must be coded on a separate claim, and the modifiers help identify the differences in the two services. The only time

Modifiers Billing Guide

that two trips may be reported on the same claim is if the zip code for the point of pick up for both trips is the same.

*****NOT ALL MODIFIER COMBINATIONS ARE COVERED BY MEDICARE.*****

Additional Modifiers for Use With Ambulance Transports

-GM Multiple patients on one ambulance trip

When more than one patient is transported in an ambulance, the Medicare allowed charge for each beneficiary is a percentage of the allowed charge for a single beneficiary transport. The applicable percentage is based on the total number of patients transported, including both Medicare beneficiaries and non-Medicare patients.

Billing Tips

- Use the "GM" modifier to identify a multiple transport.
- Submit documentation to specify the particulars of a multiple transport. The documentation must include the total number of patients transported in the vehicle at the same time and the health insurance claim numbers for each Medicare beneficiary.
- Submit the charges applicable to the appropriate service rendered to each beneficiary and the total mileage for the trip.
- Submit all associated Medicare claims for the multiple transports within a reasonable number of days of submitting the first claim.
- If there is only one Medicare beneficiary in the multiple patient transports, the supplier must document this.

-QL Patient pronounced dead after ambulance called

Time of Death Pronouncement - Ground or Water

Medicare ambulance benefits are a transport benefit. If no transport of a Medicare beneficiary occurs, then there is no Medicare covered service. In general, if the beneficiary dies before being transported, then no Medicare payment may be made. In a situation where the beneficiary dies, whether any payment under the Medicare ambulance benefits may be made depends on the time at which the beneficiary is pronounced dead by an individual authorized by the State to make such pronouncements. The chart below shows the Medicare payment determination for various ground ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary.

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Time of Death Pronouncement	Medicare Payment Determination
Before dispatch	No payment
After dispatch, before beneficiary is loaded onboard the ambulance (before or after arrival at the point of pickup).	The ambulance BLS base rate is paid. No mileage or rural adjustment. Use the QL modifier when submitting the claim.
After pickup, prior to or upon arrival at the receiving facility.	Medically necessary level of service furnished is allowed.

Air Ambulance

Medicare allows payment for an air ambulance service when the air ambulance takes off to pick up a Medicare beneficiary, but the beneficiary is pronounced dead before being loaded onto the ambulance for transport (either before or after the ambulance arrives on the scene). This is provided the air ambulance service would otherwise have been medically necessary. The allowed amount is the appropriate air base rate, i.e.; fixed or rotary wing. No amount is allowed for mileage or rural adjustment.

No payment is allowed if the dispatcher received pronouncement of death and had a reasonable opportunity to notify the pilot to abort the flight. The supplier must submit documentation with the claim sufficient to show that:

- The air ambulance was dispatched to pick up a Medicare beneficiary;
- The aircraft actually took off to make the pickup;
- The beneficiary to whom the dispatch relates was pronounced dead before being loaded onto the ambulance for transport;
- The pronouncement of death was made by an individual authorized by State law to make such pronouncements; and
- The dispatcher did not receive notice of such pronouncement in sufficient time to permit the flight to be aborted before take off.

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Air Ambulance Scenarios: Beneficiary Death	
Time of Death Pronouncement	Medicare Payment Determination
Prior to takeoff to point-of pickup with notice to dispatcher and time to abort the flight	None. Note: This scenario includes situations in which the air ambulance has taxied to the runway, and/or has been cleared for takeoff, but has not actually taken off.
After takeoff to the point of pickup, but before the beneficiary is loaded	Appropriate air base rate with no mileage or rural adjustment; use the QL modifier when submitting the claim
After the beneficiary is loaded onboard, but prior to or upon arrival at the receiving facility	As if the beneficiary had not died.

For additional billing instructions in regards to ambulance services, refer to <http://www.medicarenhic.com/providers/pubs/ambguide.pdf>

AMBULATORY SURGICAL CENTER (ASC)

Only facility charges related to a procedure approved by CMS may be reimbursed when performed in an ASC facility. The complete list of procedures can be found on the following website: <http://www.cms.hhs.gov/ascpayment>.

-SG Ambulatory Surgical Center (ASC) facility service

The -SG modifier must accompany all codes billed by an ASC.

(For dates of service on and after January 1, 2008, this modifier is no longer needed.)

***Do not use this modifier with implanted device procedure codes. To report approved implanted device procedures that have pass through status under OPPS provided in ASC facility, use the appropriate procedure code without Modifier -SG and submit a separate claim using a valid Medicare supplier identification number . For more information, refer to the Ambulatory Surgical Center Billing Guide on our website, and IOM on the CMS website.

-73 Discontinued Outpatient Hospital/ Ambulatory Surgery Center (ASC) Procedure Prior to Administration of Anesthesia: Due to extenuating circumstances or those that threaten the well being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and

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being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general).

Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier -53.

-74 Discontinued Outpatient Hospital/ Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia: Due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s) or general) or after the procedure was started (incision made, intubation started, scope inserted, etc.).

Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier -53.

-FB Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples)

-FC Partial credit received for replaced device

Note: The modifiers listed above should only be used by ASC facilities. Physicians should never use these modifiers.

For additional information regarding ASC billing, use the following link to the *Ambulatory Surgical Center Billing Guide*:

<http://www.medicarenhic.com/providers/pubs/ascguide.pdf>

ANESTHESIA

Use these modifiers with anesthesia procedure codes 00100-01999 to indicate whether the procedure was personally furnished, medically directed, or medically supervised.

Anesthesia Services Billed By The Anesthesiologist:

- AA Anesthesia services performed personally by anesthesiologist
- QY Medical direction of one CRNA by an anesthesiologist
- QK Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
- AD Medical supervision by a physician: more than four concurrent anesthesia procedures

Anesthesia Services Billed by the CRNA:

- QX CRNA service: with medical direction by a physician
- QZ CRNA service: without medical direction by a physician

Monitored Anesthesia Care (MAC)

- G8 Monitored Anesthesia Care (MAC) for deep complex, complicated, or markedly invasive surgical procedure
 - Submit this modifier **only** with anesthesia services (CPT codes 00100-01999).
 - Submit the modifier indicating personally performed, medically directed, or medically supervised first, and HCPCS modifier G8 second.
- G9 Monitored Anesthesia Care (MAC) Service for patient who has a history of severe cardiopulmonary condition
- QS Monitored Anesthesia Care service
This involves the intra-operative monitoring by a physician, or a qualified individual under the medical direction of a physician, of the patient's physiological signs, anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedures. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., atropine, Demerol, valium) and provision of indicated postoperative anesthesia care.

Note: Claims for monitored anesthesia must include the identifying procedure code along with the appropriate anesthesia modifier, plus modifier -QS. Submit the HCPCS modifier indicating that the service was personally performed or involved medical direction or medical supervision first, and submit HCPCS modifier QS second in Item 24D or the electronic equivalent.

Unusual Anesthesia

- 23 Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

Modifier 23 should be reported in the second position. Submit the modifier indicating the service was personally performed, medically directed, or medically supervised first.

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Anesthesia By Surgeon

-47 Anesthesia by surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service (This does not include local anesthesia).

NOTE: Modifier 47 would not be used as a modifier for the anesthesia procedures.

Under Medicare, prior to January 1, 2006, no separate payment is made for anesthesia when it is provided by the operating surgeon.

Note: The revised policy effective January 1, 2006 and implemented October 1, 2007 is: If the physician performing the procedure also provides moderate sedation for the procedure, then payment may be made for conscious sedation consistent with CPT guidelines. However, if the physician performing the procedure provides local or minimal sedation for the procedure, then no separate payment is made for the local or minimal sedation service.

For additional information <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5618.pdf>

For additional information on anesthesia billing:

<http://www.medicarenhic.com/providers/pubs/anesguide.pdf>

CMS Internet Only Manual, Pub 100-04, Chapter 12:

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

ASSISTANT SURGEON

Medicare will make payment for an assistant-at-surgery when the procedure is covered for an assistant and one of the following situations exist:

- The person reporting the service is a physician or
- The person bears the designation of physician assistant, nurse practitioner, nurse midwife, or clinical nurse specialist.

No other person can be paid. If the person who assists at surgery is a surgical technician, a first surgical assistant, scrub nurse, or bears any title other than those listed, the service is not payable by Medicare and is not billable to the patient.

To determine whether the services of an assistant surgeon may be submitted to Medicare, refer to the Medicare Physician Fee schedule database (MPFSDB) at the following CMS website

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=2>

To find the information for 2008, go to RVU08A and open the zip files. For the indicator definition, go to RVUPUF08. For the payment indicators, go to PPRRVU08 zip files.

-80 Assistant surgeon

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- 81 Minimum assistant surgeon
- 82 Assistant surgeon (when a qualified resident surgeon is not available)

For Modifier 82, reimbursement for services of an assistant-at-surgery in a teaching hospital which has a training program related to the specialty required for the surgical procedure and has a qualified resident available, are prohibited with the following exceptions:

- o The services are required due to exceptional medical circumstances, or
- o There is no qualified resident available, or
- o The primary surgeon has an across the board policy of never involving residents in the preoperative, operative, or postoperative care of his/her patients.

- AS PA, nurse practitioner, or clinical nurse specialist services for assistant at surgery

Coverage of services under AS is limited to those that are allowed in the state under their license.

Reimbursement

Assistant surgical services are customarily reimbursed at 16 percent of the fee schedule amount of the surgical procedure, and are subject to multiple surgery pricing rules. The allowed amount for assistant-at-surgery services performed by a nurse practitioner, physician assistant or clinical nurse specialist is the lesser of 80 percent of the actual charge, or 85 percent of the 16 percent allowed based on the physician fee schedule.

Reimbursement examples:

The example below illustrates the reimbursement of assistant-at-surgery services for a physician billing.

Code	Definition	Physician Fee Amount	Assistant-at-Reduction (16%)	Final Allowance
33300	Repair of heart wound	\$2,184.71	\$2,184.71 X 16%=\$349.55	\$349.55

The example below illustrates the reimbursement of assistant-at-surgery services for nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS).

Code	Definition	Physician Fee Amount	Assistant-At Reduction (16%)	Non-Physician Reduction (85%)	Final Allowance
33300	Repair of heart wound	\$2,184.71	\$2,184.71 X 16%=\$349.55	\$349.55 X 85% = \$297.12	\$297.12

For additional information on assistant-at-surgery billing:

CMS IOM, Pub. 100-04, Chapter 12,

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

Access the Payment Policy Indicators from the CMS website at <http://cms.hhs.gov/PFSlookup>

BILATERAL SERVICES

-50 Bilateral procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code.

Billing Tips:

- Medicare guidelines for the use of modifier -50 differ from those in the CPT manual and many third-party payers' accepted protocol.
- Bilateral procedures should only be reported with **one** procedure code appended with modifier -50. This should appear on the Form CMS-1500 as a single line item with the number of Days/Units "1".
- With the exception of certain radiology procedures, bilateral procedures are customarily reimbursed at 150% of the Medicare Fee Schedule Allowance.
- Refer to the Medicare Physician Fee Schedule database (MPFSDB) to determine if CPT modifier 50 is applicable to a particular procedure code.
- The procedure code must have a "1" indicator on the MPFSDB for the modifier -50 to apply. If a procedure is not valid for the modifier -50 or the LT/RT modifiers, there will be a "0" indicator under bilateral surgery on the MPFSDB.
<http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVE/list.asp?listpage=2>
- Medicare considers the following ophthalmologic codes bilateral. Therefore, do not use modifier -50 on 92020, 92060, 92065, 92081, 92083, 92100, 92120, 92130, 92136, 92140, 92250, 92260, 92265, 92270, 92283, 92284, 92285, 92286, 92287, 92312, 92316, 92353, 92354, 92355, 92358, 92371. If one of the above codes is performed unilaterally, bill the code with modifier -LT or -RT to indicate that one eye was treated.
- **Do not submit codes with bilateral indicator 2 with HCPCS modifier RT or LT or CPT modifier 50.**

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Bilateral Procedures Billed Incorrectly

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										
1. 717 7			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	06	01	20	07	07	21	27310			1
2	06	01	20	07	07	21	27310	50		1
3										

Bilateral Procedures Billed Correctly

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										
1. 717 7			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	06	01	20	07	07	21	27310	50		1
2										
3										

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier -50 to the appropriate five digit procedure code.

CHIROPRACTIC

-AT Acute treatment

This modifier is submitted with chiropractic treatment codes when the chiropractor furnishes *acute treatment*. It should not be used when the treatment is maintenance in nature.

- This modifier may only be submitted with CPT codes 98940, 98941, and 98942. (CPT code 98943 is not reimbursed by Medicare.)

Reference:

CMS, Pub 100-04, Chapter 15, Sections 30.5 and 240

<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>

Use the following link to the NHIC Chiropractic Billing Guide

<http://www.medicarenhic.com/providers/pubs/chiroguide.pdf>

CLINICAL PSYCHOLOGIST & CLINICAL SOCIAL WORKER

The following modifiers must be submitted on an assigned claim and when diagnostic psychological tests and therapeutic psychotherapy services are reported to Medicare. Failure to use the appropriate modifier may result in incorrect payment.

- AH Clinical psychologist
Indicates that the therapeutic service(s) reported was personally performed by a clinical psychologist.
- AJ Clinical social worker
Indicates that the therapeutic service(s) reported was personally performed by a clinical social worker.

For reimbursement rates and coverage, please refer to the Mental Health Billing Guide on the NHIC website.

Reference:

Mental Health Services Billing Guide:

<http://www.medicarenhic.com/providers/pubs/mentahlthgd.pdf>

CLINICAL RESEARCH STUDIES

- QA FDA Investigational Device Exemption
- QR Item or Service Provided in a Medicare Specified Study
- QV Item or Service Provided as Routine Care in a Medicare Qualifying Clinical Trial.

CMS discontinued the QA, QR and QV HCPCS modifiers as of December 31, 2007, and replaced them with the new modifiers Q0 and Q1 to differentiate between investigational and routine clinical service provided in a clinical research study approved by Medicare. Claims submitted for services on and after January 1, 2008, must include the two new modifiers for routine and investigational clinical services. This includes studies that are certified under the Medicare Clinical Research Policy, Investigational Device Exemption (IDE) trials, and studies required under a coverage with evidence development (CED) national coverage determination (NCD). Claims submitted with the discontinued modifiers will be returned as unprocessable for dates of service on and after January 1, 2008.

The Q0 replaces QA and QR

Q0- Investigational clinical service provided in a clinical research study that is in an approved clinical research study

NOTE: This modifier is Q0 (zero) not the letter O.

The Q1 replaces QV

Q1- Routine clinical service provided in a clinical research study that is in an approved clinical research study

For additional billing requirements for clinical trials you may refer to the following link:
<http://www.cms.hhs.gov/transmittals/downloads/R1418CP.pdf>

COMPETITIVE ACQUISITION PROGRAM (CAP)

The following modifiers may *only* be submitted by physicians that are enrolled in the COMPETITIVE ACQUISITION PROGRAM (CAP) for drugs and biologicals.

- J1 Competitive acquisition program (CAP) no pay submission for a prescription number
 - Submit HCPCS modifier J1 with the code for the drug. The prescription number is also required. Charge for the drug should be \$0.
 - HCPCS J1 and J2 may be submitted together.
 - Do not submit on same claim line as J3
- J2 Competitive acquisition program (CAP), restocking of emergency drugs after emergency administration.
 - Submit HCPCS modifier J2 with the code for the drug. By submitting this modifier, you are attesting that:
 - The drug was required immediately;
 - The drug couldn't be anticipated
 - The vendor couldn't deliver in time;
 - The drug was administered in an emergency situation; and
 - Documentation is on file and available upon request to validate the emergent nature of the situation.

HCPCS J1 and J2 may be submitted together. The prescription number is also required.
- J3 Competitive acquisition program (CAP), drug not available through CAP as written, reimbursed under average sales price methodology
 - Submit HCPCS modifier J3 for "furnish as written" drugs to be paid outside of the CAP program (drugs not available through CAP).
 - Do not submit on same claim line as J1 or J2 modifier.
 - Maintain documentation in the patients medical records.
- JW Drug amount discarded / not administered to any patient
 - If a physician *must* discard the remainder of a vial or other package after administering it to a Medicare patient, the program covers the amount of drug that is reasonable and necessary for the patient's condition.

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- Submit this modifier when submitting a claim for drugs that are discarded, not administered to a Medicare patient. Submit the used and unused portions of the drug on a single detail line.
- Providers should make every effort to schedule patients in a way that will minimize any waste and use of the drug most efficiently.
- The coverage of discarded drugs applies only to single use vials. Multi-use vials are not subject to payment for discarded amounts of drugs. An amount wasted must be clearly documented in the patients chart.

NOTE:

On and after August 23, 2007, claims submitted for dates of service July 1, 2007 and after that contain the JW modifier or a duplicate prescription number will be rejected and returned as unprocessable. In addition, claims that contain invalid modifier combinations will also be rejected and returned as unprocessable

-M2 Medicare secondary payer (MSP) (CAP)

- Submit this modifier when the participating physician obtains a CAP drug from a source other than the CAP vendor because of a mistake in identifying the patient's primary insurer.
- For dates of service prior to 1/1/2007, refer to HCPCS modifier J3.

For additional information:

Billing tip sheet: www.cms.hhs.gov/CompetitiveAcquisforBios/Downloads/cap_billtips.pdf

CMS website: http://cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp

CMS Pub. 100-04, Chapter 17, section 100.2:

<http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf>

DRUGS AND BIOLOGICALS

-KD Drug or biological infused through DME

- This modifier is valid for certain services submitted to DME Regional Carriers or DME Medicare Administrative Contractors.
- An implanted infusion pump for chronic pain is covered by Medicare. Claims for infusion drugs furnished through DME (Durable Medical Equipment) shall be identified using the "KD" modifier. Since the infusion of medications take place through an implantable pump, you must add the "KD" modifier to the drug code. When using medications for infusion, use the HCPCS code assigned to that medication (e.g., J2275, morphine sulfate, preservative-free sterile solution, per 10 mg) plus the KD modifier.

Modifiers Billing Guide

For further information on billing for infusion pumps and medications used through the pump, see the Local Coverage Determination and related articles at <http://www.medicarenhic.com> under the LCDs/Policy Indices.

ERYTHROPOIESIS STIMULATING AGENTS (ESA)

- EJ Subsequent claim for a defined course of therapy, e.g., EPO, sodium hyaluronate, infliximab
- Enter this modifier to indicate subsequent EPO injection.
 - This modifier is purely informational for Medicare use.

ROUTE OF ADMINISTRATION

Effective for claims submitted with dates of service on or after January 1, 2007, all providers that submit claims for injections of erythropoiesis stimulating agents (ESA) for ESRD beneficiaries are encouraged to include route of administration modifiers.

- JA Administered intravenously
- This modifier is informational only and may be submitted with injection codes Q4081, J0882 or J0886.
- JB Administered subcutaneously
- This modifier is informational only and may be submitted with injection codes Q4081, J0882 or J0886.
 - At this time, reporting these modifiers is voluntary.

Updated Coverage and Claims Requirements

Hematocrit or Hemoglobin Reporting

Effective January 1, 2008, claims for the following must report the most recent hematocrit or hemoglobin reading:

1. All claims for the administration of an ESA (HCPCS J0881, J0882, J0885, J0886 and Q4081).
2. All claims for the administration of a Part B anti-anemia drug that is not self-administered (other than ESAs) used in the treatment of cancer.

The hematocrit or hemoglobin level should be reported in Item 19 of the Form CMS-1500. The test results shall be entered as follows: TR= test results (slash), R1=hemoglobin, or R2=hematocrit (slash), and the most current numeric test result figure up to 3 numerics and a decimal point [xx.x]).

Example for hemoglobin tests:

19. RESERVED FOR LOCAL USE

TR/R1/9.0

Example for Hematocrit tests:

19. RESERVED FOR LOCAL USE

TR/R2/27.0

For electronic claims (837P), providers should report the hemoglobin or hematocrit readings in Loop 2400 MEA segment. The specifics are:

MEA01=TR (for test results),

MEA02=R1 (for hemoglobin), or R2 (for hematocrit), and
MEA03=the test results.

Required Modifiers

Effective January 1, 2008, all non-ESRD claims billing HCPCS J0881 and J0885 must also begin reporting one of the following modifiers:

- EA Erythropoetic stimulating agent (ESA) administered to treat anemia due to anticancer chemotherapy
- EB Erythropoetic stimulating agent (ESA) administered to treat anemia due to anticancer radiotherapy
- EC Erythropoetic stimulating agent (ESA) administered to treat anemia due to anticancer radiotherapy or anticancer chemotherapy

ESAs administered for more than one of the indicated therapies are to be billed as separate line items; i.e., ESAs for chemo-induced anemia, (EA modifier) are reported as separate line items (e.g., J0881EA); ESAs for radio-induced anemia (EB modifier) are reported as separate line items (e.g., J0885EB); ESAs for non-chemo/radio induced anemia (EC modifier) are reported as separate line items (e.g., J0881EC).

Only one of the three ESA modifiers may be reported at the line item level. Claims that are billed without the required modifiers will be returned as unprocessable.

Note:

Providers should continue to utilize modifier EJ to report subsequent administrations of ESAs.

National Coverage Determination

In addition to the information above, CMS has issued a National Coverage Determination (NCD) titled, "The Use of ESAs in Cancer and Other Neoplastic Conditions." This NCD lists coverage criteria for the use of ESAs in patients who have cancer and experience anemia as a result of chemotherapy or as a result of the cancer itself. The full NCD can be viewed in Publication 100-03 of the NCD Manual, section 110.21.

Effective for claims with dates of service on and after January 1, 2008, non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EC (ESA, anemia, non-chemo/radio) shall be denied when any one of the following diagnosis codes is present on the claim:

- o any anemia in cancer or cancer treatment patients due to folate deficiency (281.2),
- o B-12 deficiency (281.1, 281.3),
- o iron deficiency (280.0-280.9),
- o hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9-283.10, 283.19), or
- o bleeding (280.0, 285.1),
- o anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91); or
- o erythroid cancers (207.00-207.81).

Effective for claims with dates of service on and after January 1, 2008, services for non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EC (ESA, anemia, non-chemo/radio) shall be denied when any of the following is reflected on the claim:

- o any anemia in cancer or cancer treatment patients due to bone marrow fibrosis,
- o anemia of cancer not related to cancer treatment,
- o prophylactic use to prevent chemotherapy-induced anemia,
- o prophylactic use to reduce tumor hypoxia,
- o patients with erythropoietin-type resistance due to neutralizing antibodies; and
- o anemia due to cancer treatment if patients have uncontrolled hypertension.

Effective for claims with dates of service on and after January 1, 2008, non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EB (ESA, anemia, radio-induced) shall be denied.

Effective for claims with dates of service on and after January 1, 2008, services for non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EA (ESA, anemia, chemo-induced) shall be denied for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin 10.0g/dL or greater or hematocrit 30.0% or greater is reported.

NOTE: ESA treatment duration for each course of chemotherapy includes the 8 weeks following the final dose of myelosuppressive chemotherapy in a chemotherapy regime.

Modifiers Billing Guide

Effective for claims with dates of service on and after January 1, 2008, Medicare contractors shall have discretion to establish local coverage policies for those indications not included in NCD 110.21. NHIC has established Local Coverage Determination (LCD) L17753 for ESA administration. This LCD can be found at http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=17753&lcd_version=55&show=all.

Denials of claims for ESAs are based on reasonable and necessary determinations established by NCD 110.21. A provider may have the beneficiary sign an Advanced Beneficiary Notice, making the beneficiary liable for services not deemed reasonable and necessary and thus not covered by Medicare.

For additional information:

CMS Change Request 5699 at <http://www.cms.hhs.gov/transmittals/downloads/R1412CP.pdf>

CMS Change Request (CR) 5480 at

<http://www.cms.hhs.gov/transmittals/downloads/R1212CP.pdf>

CMS Pub. 100-04, Chapter 8, section 60.2.3.1

<http://www.cms.hhs.gov/manuals/downloads/clm104c08.pdf>

EVALUATION AND MANAGEMENT (E/M)

Report the modifiers listed below on E/M codes only.

- 21 Prolonged Evaluation and Management Services: When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be reported by adding modifier 21 to the evaluation and management code number. A report is required.

CMS has classified this modifier as “informational only” for which no additional reimbursement is allowed. Although the description indicates a report may be appropriate, **please do not submit any reports.**

- 24 Unrelated evaluation and management service by the same physician during the postoperative period

Modifier -24 was intended for use with the E/M service or eye exam codes performed during the postoperative period for a reason(s) unrelated to the original major or minor surgery. It is not to be used for medical management of a patient by the surgeon following surgery.

Billing Tips:

- Use of the -24 modifier is appropriate with CPT codes 99201-99499 and 92012-92014.

Modifiers Billing Guide

- Services submitted with modifier -24 must be sufficiently documented in the medical record to establish that the visit was unrelated to the condition for which the surgery was performed. Do not submit the documentation unless requested to do so.
- Append modifier -24 to the E/M code performed during a pre or postoperative period of a procedure performed by the same physician, but which is unrelated to the major or minor surgical procedure performed.
- When submitting modifier 24 with codes (99291-99292), documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted.

Examples of Supporting Documentation:

- ICD-9-CM code(s) that are **clearly** unrelated to the surgery
- Documentation clearly explaining why the visit is unrelated to the surgery.
- Documentation indicating “immunosuppressive therapy” for organ transplants.

To determine the global period of a surgery, refer to the Medicare Physician Fee Schedule database (MPFSDB). Access the database directly from the CMS Website at <http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=2>

There is a Global Surgery Period Calculator available on the NHIC website under “Self-Service Tools” that will assist in determining the end of the global period for major surgeries.

- 25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately, identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

A significant, separately identifiable E/M service is defined or substantiated by the documentation that satisfies the relevant criteria for the respective service to be reported. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. Documentation in the patient’s medical record must support the use of this modifier.

Note: This modifier is not used to report an E/M service that resulted in a decision to perform major surgery (i.e., those with a 90-day follow-up period). See modifier -57. For significant, separately identifiable non E/M services, see modifier 59.

Modifiers Billing Guide

Example:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)											
216		8									↓
1. _____			3. _____								
2. _____			4. _____								
24. A.	DATE(S) OF SERVICE					B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES			E.
	From			To		PLACE OF		(Explain Unusual Circumstances)		DIAGNOSIS	
	MM	DD	YY	MM	DD	SERVICE	EMG	CPT/HCPCS	MODIFIER	POINTER	
1	09	01	2007	09	01	2007	11		99213	25	1
2	09	01	2007	09	01	2007	11		17000		1
3											

Billing Tips:

No supporting documentation is required with the claim when this modifier is submitted. However, the patient's medical records must contain information to support the use of modifier -25 and be available upon request. The following are the exceptions:

- This modifier should not be submitted with E/M codes that are explicitly for new patients only: 92002, 92004, 99201-99205, 99281-99285, 99321-99323, and 99341-99345. These services are not considered part of the global surgical policy.
- Use modifier -25 on initial hospital visit (99221-99223), an initial inpatient consultation (99251-99255) and a hospital discharge service (99238 and 99239), when billed for the same date as an inpatient dialysis service.
- Use modifier -25 when preoperative critical care codes (**99291-99292**) are billed within a global surgical period. Reporting these E/M services with modifier -25 indicates that they are significant and separately identifiable. Documentation that 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 procedure performed must be submitted.
- Use modifier -25 on an E/M service when performed at the same session as a preventive care visit when a significant, separately identifiable and medically necessary E/M service is performed in addition to the preventive care. The E/M must be carried out for a non-preventive clinical reason, and the ICD-9-CM code(s) for the E/M service should clearly indicate the non-preventive nature of the E/M service.
- Use modifier -25 if the decision for surgery is made on the same day as a minor surgery (i.e., those with a 0 or 10- day follow-up period) if the decision is made during an E/M service the day of surgery.
- This modifier may be used to indicate that an E/M service was provided on the same day as another procedure that would normally bundle under National Correct Coding Initiative (NCCI). In this situation, modifier -25 signifies that

Modifiers Billing Guide

the E/M service was performed for a reason unrelated to the other procedure. Access the CMS website for the National Correct Coding Initiative at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage>.

- o Do not use modifier -25 on a surgical code (10021-69999) since this modifier is used to explain the special circumstance of providing the E/M service on the same day as a procedure.

NOTE: *The most common cause for claim denial of an unrelated E/M service billed on the same day as another procedure or during the post operative period for a non-surgery related reason is due to the omission of modifier -25.*

Multiple Modifiers May Apply

- o When a visit occurs on the same day as a surgery with “0” global days and within the global period of another surgery AND the visit is unrelated to both surgeries, modifiers 24 and 25 must be submitted. For example: A patient comes to the office for consultation and an endoscopic procedure is performed. The results require immediate performance of major surgery the next day. The consultation would require the use of modifier -24 for the endoscopic procedure, and -25 for the major surgery performed the next day.
- 57 Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier -57 to the appropriate level E/M service

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										
1. 428		0		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	06	01	20	07	07	11		99212	57	1
2	06	02	20	07	07	21		33945		1
3										

Note:

Modifier -57 is only used with evaluation and management services performed within 24 hours of a major procedure. The global period for a major procedure includes the day before, the day of, and the 90 days immediately following the procedure.

Modifiers Billing Guide

Billing Tips:

- E/M services on the day before the procedure, the day of the procedure, and within the 90-day postoperative period are generally not payable. Only initial services and services unrelated to the procedure performed may be considered for payment.
- Do not use Modifier -57 with minor surgeries (zero- to 10 day postoperative period). See Modifier 25.
- No supporting documentation is required with the claim when submitted but must be included in the patient's medical record and available upon request.

For additional information: refer to the "General Surgery Billing Guide" on the NHIC website at <http://www.medicarenhic.com/providers/pubs/surgeryguide.pdf>

CMS Internet Only Manual (IOM) Pub. 100-04, Chapter 12

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

To determine the global period of a surgery, refer to the Medicare Physician Fee Schedule database (MPFSDB) on the CMS Website:

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=2>.

EYE

Use the appropriate modifier for additional information when billing eye procedures.

- AP Determination of refractive state was not performed in the course of diagnostic ophthalmologic examination
 - May be submitted with CPT codes 92002, 92004, 92012 and 92014.
 - Because this modifier is informational only, submit in the last modifier position after any other appropriate modifiers.
- LS FDA- monitored intraocular lens implant
 - Submit this modifier on physician claims for eye surgery with IOL implants
- VP Aphakic patient
 - Submit this modifier with Evaluation and Management (E/M) codes or eye exam codes to indicate that the patient is aphakic.
 - This modifier is informational only.

The following modifiers are often used for procedures or diagnostic tests that may be bundled when performed on the same eye(s):

- E1 Upper left eyelid
- E2 Lower left eyelid
- E3 Upper right eyelid
- E4 Lower right eyelid

For additional information: refer to the “Ophthalmology/Optomety Billing Guide” at <http://www.medicarenhic.com/providers/pubs/eyeguide.pdf>

FOOT CARE

Routine foot care is not a covered Medicare benefit. Medicare assumes that the beneficiary or caregiver will perform these services by themselves, and therefore, they are excluded from coverage. Medicare allows exceptions to this exclusion when medical conditions exist that place the patient at increased risk of infection and/or injury if a non-professional would provide these services. Medicare may cover routine foot care in the following situations:

- **The routine foot care is a necessary and integral part of otherwise covered services**
- **The patient has a systemic condition**

To fulfill the claim billing requirements for qualified routine foot care in vascularly compromised patients, one of the following modifiers must be attached to each routine foot care procedure code (CPT codes 11719, 11720, 11721 or G0127).

- Q7 One Class A finding
- Q8 Two Class B findings
- Q9 One Class B and two Class C findings

Routine Foot Care Class Findings

Class findings represent specific *medical findings* that must be present clinically and *documented* in the medical record in order to qualify routine foot care reimbursement in the *vascularly compromised* patient.

The medical record should contain clinical findings consistent with the diagnosis and indicative of severe and clinically peripheral involvement.

Class A - Nontraumatic amputation of the foot or integral skeletal portion thereof

Class B -Absent posterior tibial pulse
-Advanced trophic changes; three of the following are required:
Hair growth (decrease or absence)
Nail changes (thickening)
Pigmentary changes (discoloration)
Skin texture (thin, shiny)
Skin color (rubor or redness)

Class C -Absent dorsalis pedis pulse
-Claudication

Modifiers Billing Guide

- Temperature changes (e.g., cold feet)
- Edema
- Paresthesia (abnormal spontaneous sensations in the feet)
- Burning

Note: To be considered for coverage when utilizing the class findings, they must be documented in the medical record for each date of service routine foot care is qualified. They must contain clinical findings consistent with the diagnosis, and be indicative of clinically significant peripheral involvement. Please refer to the routine foot care Local Coverage Determinations (LCD's) on the NHIC website.

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA)

Federal Law permits special payment for professional services provided by physicians in federally designated geographic Health Professional Shortage Areas (HPSAs). Physicians who provide covered Medicare services in rural or urban HPSAs are eligible for a 10-percent incentive payment.

The Health Resources and Services Administration, with the Department of Health & Human Services, is responsible for designating shortage areas. Eligibility for the incentive payment is based on provider specialty and the location where the services were rendered, not necessarily where the physician maintains an office.

HPSA boundaries are based on census tracts, and in many cases do not coincide with routinely used boundaries such as ZIP codes or streets. Census tract information can be located at <http://www.ffiec.gov/geocode/default.htm>

-AQ Physician providing a service in an unlisted Health Professional Shortage Area

Submit modifier -AQ in the following instances:

- When you provide services in zip code areas that do not fall entirely within a designated full county HPSA bonus area;
- When you provide services in a zip code area that falls partially within a full county HPSA but is not considered to be in that county based on the USPS dominance decision;
- When you provide services in a zip code area that falls partially within a non-full county HPSA;
- When you provide services in a zip code area that was not included in the automated file of HPSA areas based on the date of the data run used to create the file.

Do not submit modifier -AQ in the following instances:

- Your global code contains a technical component
- You are submitting a technical-only component code (e.g., CPT 93005).

Modifiers Billing Guide

- The service was not rendered in a HPSA.
- The service was performed by someone that does not meet the definition of a physician (psychiatrists are included in the definition of a physician).
- You have elected to “opt out” of the HPSA program.
- The dates of service are before January 1, 2006.

-AR Physician provider services in a Physician Scarcity Area

Submit modifier –AR in the following instances:

- Check the automated pay zip code lists under Primary Care or Specialty links first: <http://www.cms.hhs.gov/hpsapsaphysicianbonuses/>. If your zip code is on either list, you do not have to use HCPCS modifier AR. Medicare will pay the bonus payment to you automatically if the zip code where the service was provided is on either list.
- Medicare will pay a five percent PSA bonus on a quarterly basis, and the bonus will be based on what Medicare actually paid not on the Medicare-approved payment amount.
- A single service may be eligible for the PSA bonus and the HPSA bonus.
- Payment will be based on where the service is performed and not on the address of the beneficiary.
- The PSA bonus will be paid on services rendered on or after January 1, 2005 through June 30, 2008. Look for future updates to this policy on the NHIC website.

Incentive Eligible Services

To determine whether the HPSA bonus payment will automatically be paid for services rendered in your area, please review the information provided on the CMS website at <http://www.cms.hhs.gov/hpsapsaphysicianbonuses/>.

For additional information:

CMS Pub. 100-04, Chapter 12 Section 90.4

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

CMS Pub. 100-04, chapter 12, section 90.4.5 and 90.5:

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

HOSPICE

The following modifiers should be used in regards to Hospice billing.

-GV: Attending physician not employed or paid under arrangement by the patient's hospice provider

This modifier must be submitted when a service meets the following conditions, regardless of the type of provider:

- The service was rendered to a patient enrolled in a hospice, and
- The service was provided by a physician or non-physician practitioner identified as the patient’s “attending physician” at the time of that patient’s enrollment in the hospice program.

Modifiers Billing Guide

- Submit this modifier regardless of whether the services were related to the patient's terminal condition.

Do not submit this modifier:

- If the service was provided by a physician employed by the hospice or
- If the service was provided by a physician not employed by the hospice and the physician was not identified by the beneficiary as his/her attending physician

-GW: Service not related to the hospice patients terminal condition

- Submit this modifier when a service is rendered to a patient enrolled in a hospice, and the service is *unrelated* to the patient's terminal condition. **All** providers must submit this modifier when this condition applies.

For additional information: CMS Pub. 100-02, chapter 9:

<http://www.cms.hhs.gov/manuals/Downloads/bp102c09.pdf>

CMS Pub. 100-02, chapter 15, section 270.2: <http://www.cms.hhs.gov/manuals/IOM/list.asp>

LABORATORY SERVICES

-LR Laboratory round trip

- This modifier may *only* be submitted by independent clinical laboratories for HCPCS code P9604.

-QP Documentation is on file showing that the laboratory test(s) was ordered individually or ordered as a CPT-recognized panel other than automated profile codes 80002-80019, G0058, G0059 and G0060

- Submit this modifier when the laboratory test was ordered as a single test or when a single code is available for a grouping of tests. This modifier indicates that the test was ordered individually or ordered as a CPT-recognized panel other than automated profile codes 80002-80019 and HCPCS codes G0058-G0060. This modifier may be submitted with the following codes:
 - CPT codes 80002-89399
 - HCPCS codes G0026-G0027
 - HCPCS codes G0058-G0060
 - HCPCS code G0107
 - HCPCS codes P2028-P2031
 - HCPCS codes P2033-P2038
 - HCPCS codes P3000-P3001
 - HCPCS codes P9010-P9022
 - HCPCS codes Q0111-Q0015

-QW CLIA test waived

Modifiers Billing Guide

The Centers for Disease Control and Prevention (CDC) has established several tests, and periodically revises the list of tests, which may be performed by entities holding a CLIA Certificate of Waiver or a higher level CLIA certificate. These tests must be billed with the correct CPT code and modifier QW to be considered for payment. Providers can find a list of CLIA waived tests and those tests that require the use of the “QW” modifier at http://www.cms.hhs.gov/CLIA/10_Categorization_of_Tests.asp.

Billing Tips

- Submit this modifier with clinical laboratory tests that are waived from the Clinical Laboratory Improvement Amendments of 1988 (CLIA) list.

Note: Not all CLIA-waived tests require HCPCS modifier QW. Refer to the published lists to determine which codes require a modifier.

- Determine if the CPT code is a waived test by accessing the CMS CLIA Web page: http://www.cms.hhs.gov/CLIA/10_Categorization_of_Tests.asp#TopOfPage
- The CLIA certificate number is also required on claims for CLIA waived tests. Submit this information in Loop 2300 or 2400, REF/X4, 02 for electronic claims. For paper claims, submit the CLIA certification number in Item 23 of the CMS-1500 claim form.

- 90 Reference (outside) laboratory: When laboratory procedure are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier -90 to the basic procedure.
- This modifier may only be submitted with clinical laboratory tests.
 - Independent clinical laboratories may submit this modifier to indicate that the service was referred to an outside laboratory.

For all laboratory work referred to an outside lab, Item 32 or electronic equivalent must reflect the place where the test was performed. The NPI and / or legacy number are not required in 32a or 32b.

- 91 Repeat Clinical Diagnostic Laboratory Test: In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure code and the addition of modifier -91.
- This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

-92 Alternative Laboratory Platform Testing: When testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701-86703). The test does not require permanent dedicated space; hence by its design it may be hand carried or transported to the vicinity of the patient for immediate

testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

NATIONAL CORRECT CODING INITIATIVE (NCCI)

CMS developed the National Correct Coding Initiative (also referred to as CCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. CCI edits are pairs of CPT or HCPCS Level II codes that are not separately payable under certain circumstances. The edits are applied to services billed by the same provider for the same beneficiary on the same date of service. All claims are processed against CCI tables.

-59 Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier -59 is used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under the circumstances.

Documentation must support:

-a different session

-different procedure or surgery

-different site or organ system

-separate incision or excision

-separate lesion

-separate injury (or area of injury in extensive injuries)

not normally encountered on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances should modifier 59 be used.

Modifiers Billing Guide

Billing Tips:

- Modifier -59 is an important National Correct Coding Initiative (NCCI) associated modifier that is often used incorrectly.
- For the NCCI, the primary purpose of Modifier -59 is to indicate that two or more procedures are performed at different anatomic sites or during different patient encounters.
- Before submitting this modifier, it is important to verify whether the services are bundled through NCCI. NCCI edits are updated quarterly and may be accessed at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage>.
- Modifier -59 **should not be used** to bypass an NCCI edit, unless the proper criteria for use of the modifier is met and fully documented in the medical records.
- Modifier -59 is used only on the procedure which is designated as the distinct procedural service.
- Modifier -59 is used only if another modifier does not describe the situation more accurately or when its use best explains the circumstances. (See the additional modifiers listed in this section.)
- No special documentation need be submitted with the claim when modifier -59 is used.
- In all cases, documentation must be maintained in the patient's medical records to support the use of modifier -59 and must be made available upon request.
- Modifier -59 should not be used with an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.
- Procedure codes that are billed to Medicare and denied due to NCCI may not be billed to the patient.

Example: Distinct Procedural Service

1	Column1/Column 2 Edits					
2	Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date * = no data	Modifier 0 = not allowed 1 = allowed 9 = not applicable
16412	17000	01995		20020701	20061231	0
16413	17000	11000		19980401	*	1
16414	17000	11001		19960101	19960101	9
16415	17000	11040		19980401	*	1
16416	17000	11041		19980401	*	1
16417	17000	11042		19980401	*	1
16418	17000	11100		19970101	*	1
16419	17000	11719		19990401	*	1
16420	17000	11900		19980401	*	1
16421	17000	11901		19980401	*	1
16422	17000	17281		19990701	19990701	9
16423	17000	36000		20021001	*	1
16424	17000	36410		20021001	*	1
16425	17000	37202		20021001	*	1
16426	17000	62318		20021001	*	1

Modifiers Billing Guide

1 st Column	(Shaded area) This is just the number (counting) of that particular edit.
2 nd Column	This is a listing of CPT/HCPCS codes. The CPT/HCPCS code listed in "COLUMN 1" is the most comprehensive code.
3 rd Column	The CPT/HCPCS code in "COLUMN 2" will not be paid on the same day as the code in "COLUMN 1".
4 th Column	This column lets you know if the edit was in existence prior to 1996.
5 th Column	This is the effective date of the edit.
6 th Column	This is the termination date of the edit(if applicable).
7 th Column	<p>This is the modifier column.</p> <ul style="list-style-type: none"> • Code pairs identified with indicator "0" cannot be submitted for reimbursement under any circumstances. The code in column 2 will never be paid on the same day as the column 1 code. • Code pairs identified with indicator "1" <i>may</i> be submitted separately if there is documentation in the medical records to support that the services are distinct or independent of one another. <p>Code pairs identified with indicator "9" are not subject to CCI edits. No modifier is required.</p>

- CPT 17000 (CCI- Column I code): Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettment), premalignant lesions (e.g., actinic keratoses); first lesion, **submitted with**
- CPT 11000 (CCI-column II code): Biopsy of skin, subcutaneous tissue and/ or mucous membrane (including simple closure), unless otherwise listed; single lesion

Rationale:

- Correct usage of modifier -59 is based on CPT coding manual instructions and guidelines.
- Modifier -59 is only appropriate if the procedures are performed on separate lesions or at separate patient encounters.

Modifiers Billing Guide

Coronary Artery

Use these modifiers to indicate the specific vessel involved in the procedure; they are only valid for CPT codes 92980, 92981, 92984, 92995 and 92996.

- LC Left circumflex coronary artery
- LD Left anterior descending coronary artery
- RC Right coronary artery

Digit Modifiers For The Foot

With some procedure codes, it is appropriate to report a digit modifier indicating the toe upon which the procedure was performed. A toe is defined as that appendage structure distal to the mid-metatarsal-phalangeal joint. Digit modifiers are:

TA	Left foot, great toe	T5	Right foot, great toe
T1	Left foot, second digit	T6	Right foot, second digit
T2	Left foot, third digit	T7	Right foot, third digit
T3	Left foot, fourth digit	T8	Right foot, fourth digit
T4	Left foot, fifth digit	T9	Right foot, fifth digit

Digit Modifiers For The Hand

FA	Left hand, thumb	F5	Right hand, thumb
F1	Left hand, second digit	F6	Right hand, second digit
F2	Left foot, third digit	F7	Right hand, third digit
F3	Left foot, fourth digit	F8	Right hand, fourth digit
F4	Left foot, fifth digit	F9	Right hand, fifth digit

Eye Modifiers

- E1 Upper left eyelid
- E2 Lower left eyelid
- E3 Upper right eyelid
- E4 Lower right eyelid

Other

- LT Left side (used to identify procedures performed on the left side of the body)
- RT Right side (used to identify procedures performed on the right side of the body)

For additional information: refer to the "Foot Care Billing Guide" on the NHIC website <http://www.medicarenhic.com/providers/pubs/footguide.pdf>

The Medicare Benefit Policy Manual, Publication 100-2, Chapter 15 can be found at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>

Modifiers Billing Guide

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0707.pdf>

The NCCI edits and an overview of the initiative can be found at the following link:

http://www.cms.hhs.gov/NationalCorrectCodInitEd/01_overview.asp

The related MLN Matters article SE0715 can be found at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0715.pdf>

OUTPATIENT THERAPY SERVICES

Providers are required to report one of the following modifiers to distinguish the type of therapist who performed the outpatient service. If the service was not delivered by a therapist, it is used to report the discipline of the Plan of treatment/care under which the service is delivered.

- GN Service delivered under an outpatient speech language pathology plan of care
- GO Service delivered under an outpatient occupational therapy plan of care
- GP Service delivered under an outpatient physical therapy plan of care

Additional Modifier For Outpatient Therapy Services

- KX Requirements Specified in the medical policy have been met
 - Submit this modifier with speech language pathology, physical therapy or occupational therapy services when the patient has already met the financial cap for PT/SLP or OT *and* the service qualifies as an “exception” to be reimbursed over and above the cap.
 - You must include HCPCS modifier KX on the claim identified as a therapy service in addition to HCPCS modifier GN, GO, or GP when a therapy cap exception has been approved, or it meets all the guidelines for an automatic exception. This allows the approved therapy services to be paid, even though they are above the therapy cap financial limits.
 - Do not add modifier KX to any line of service that is not medically necessary.
 - If additional modifiers are required with the service, HCPCS modifiers GN, GO or GP must be submitted in the first or second modifier position.

For additional information: refer to the “Physical and Occupational Therapy Billing Guide”
<http://www.medicarenhic.com/providers/pubs/ptotguide.pdf>.

Requirements for therapy plans of care: CMS Pub. 100-02, chapter 15, section 220:
<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>

PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI)

The Physician Quality Reporting Initiative (PQRI) establishes a financial incentive for eligible professionals to participate in a voluntary quality reporting program.

In 2008, there are 119 measures that make up the 2008 Physician Quality Reporting Initiative (PQRI). There were 74 measures in 2007. In general, the quality measures consist of a numerator and a denominator that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome.

Where a patient falls in the denominator population but specifications define circumstances in which a patient may be excluded from the measure's denominator population, CPT Category II code modifiers 1-P, 2-P, or 3-P are available to describe medical, patient, or system reasons, respectively, for such exclusion.

- 1P Performance Measure Exclusion Modifier due to Medical Reasons (e.g., such as patient allergic to medicine)
- 2P Performance Measure Exclusion Modifier used due to Patient Reason (e.g., such as patient refused treatment)
- 3P Performance Measure Exclusion Modifier used due to System Reason (e.g., such as flu shot shortage)

Where an exclusion does not apply, the CPT Category II modifier 8-P may be used to indicate a situation when the patient is eligible but an action described in a measure is not performed and the reason is not specified or documented.

- 8P Performance Measure Reporting Modifier-action not performed, reason not otherwise specified

Billing Tips:

- One or more exclusions may be applicable for a given measure. Certain measures have no applicable exclusion modifiers. Refer to each quality measure for specific indications.
- CPT II modifiers may only be reported with CPT II codes and cannot be used with G codes.
- Only PQRI modifiers should be used with the PQRI codes. Do not use any other modifiers.

For additional information refer to the CMS website for Physician Quality Reporting Initiative: <http://www.cms.hhs.gov/PQRI>.

PORTABLE X-RAY

One of the following modifiers is required when reporting HCPCS code R0075 (transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen).

- UN Two patients served
- UP Three patients served
- UQ Four patients served
- UR Five patients served
- US Six patients served

Note: The units field for R0075 will always be reported as "1". This number indicates the number of patients seen at a particular location, not the number of services received by the beneficiary.

RECIPROCAL AND LOCUM TENENS ARRANGEMENTS

Physicians or group practices may retain other physicians to take over a professional practice when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education.

- Q5 Service furnished by a substitute physician under a reciprocal billing arrangement

Note:

Payment made for services provided under a reciprocal billing arrangement can be made only if the following conditions are met:

- The regular physician is unavailable to provide the visit services.
- The Medicare beneficiary has arranged for or seeks to receive the visit services from the locum tenens physician; and
- The substitute physician *does not* provide the visit services to Medicare patients over a continuous period of longer than 60 days.
- The regular physician identifies the services as substitute physician services meeting the requirements by entering the -Q5 modifier after the procedure code in Item 24d of the Form CMS-1500.

If the only substitution services a physician performs in connection with a operation are post-operative services furnished during the period covered by the global fee, these services do not need to be identified on the claim as substitution services.

A physician may have reciprocal arrangements with more than one physician. The arrangement need not be in writing.

Note: By entering the -Q5 modifier, the regular physician (or the medical group, where applicable) is certifying that the services are covered visit services furnished by the substitute physician. These services are identified in a record of the regular physician, which is available for inspection upon request, and are services for which the regular physician (or group) is entitled under this section to submit claim.

-Q6 Service furnished by a locum tenens physician

In the case of locum tenens arrangements, the substituting physician generally has no personal practice and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed per diem, with the substitute physician having the status of an independent contractor rather than an employee. These substitute physicians are generally called "locum tenens" physicians.

The requirements for the submission of claims under locum tenens billing arrangements are the same for assigned and non-assigned.

For solo practice arrangements, the billing "absentee" physician/provider NPI must continue to be reported in Item 33 and b of the Form CMS-1500. For group practice arrangements the "absentee" provider's NPI must be entered in Item 24J and the group practice NPI number in Item 33 a and b.

NOTE: On and after May 23, 2008, only the NPI must be used in Item 33a.

SURGERY

Global Surgical Split Billing (Transfer Of Care Between Providers)

If different physicians perform portions of the global service, modifiers should be used with the surgical procedure code having a 90 day postoperative period to indicate what portion of the service each provided. Each physician will be reimbursed a percentage of the global fee. The percentages allocated for pre-operative, intra-operative and post-operative services will vary for each surgical procedure (refer to the MPFSDB). The sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provided all services.

- 54 Surgical Care Only: When one physician performs a surgical procedure and another provides postoperative management, surgical services may be identified by adding modifier -54 to the usual procedure number.
- 55 Postoperative Management Only: When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier -55 to the usual procedure number.

Modifiers Billing Guide

Physicians who share postoperative management must coordinate their billing. Physicians who share postoperative management with another physician must submit information on their claims showing when they assumed or relinquished responsibility for the postoperative care. In item 19 of the Form CMS-1500 or the electronic equivalent enter "Assumed Post-op Date=MM/DD/CCYY" or "Relinquished Post-op Date = MM/DD/CCYY."

19. RESERVED FOR LOCAL USE										
RELINQUISHED POSTOP DATE = 5/2/07										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										
1. 813 43			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			
From To				CPT/HCPCS MODIFIER						
MM	DD	YY	MM	DD	YY					
04	30	2007	04	30	2007	21		66985	55	1

19. RESERVED FOR LOCAL USE										
ASSUMED POSTOP DATE = 5/3/07										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										
1. 813 43			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			
From To				CPT/HCPCS MODIFIER						
MM	DD	YY	MM	DD	YY					
04	30	2007	04	30	2007	21		66985	55	1

-56 Preoperative Management Only: When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding the modifier -56 to the usual procedure number.

This modifier is not valid for Medicare claims.

Staged Procedures

-58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period: It may be necessary to indicate that the performance of a procedure or service during the postoperative period was:

- Planned or anticipated (staged);
- More extensive than the original procedure; or

Modifiers Billing Guide

- For therapy following a surgical procedure.

Example: When a mastectomy is performed during the postoperative period of a breast biopsy, the mastectomy should be submitted with modifier -58.

- It is generally not appropriate to submit modifier -58 with CPT codes 65855, 66761, 66762, 67101, 67141, 67208, 67210, 67218, 67227, and 67228. The narrative description for these codes includes the phrase “one or more sessions”.

A new postoperative period begins when the next procedure in the staged procedure series is billed.

For treatment of a problem that requires a return to the operating/procedure room (e.g., unanticipated clinical condition) see modifier -78. When the CPT description of a procedure includes multiple treatments or stages modifier -58 is inappropriate.

Co-Surgery And Surgical Teams

- 62 Two Surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier -62 to the procedure code and any associated add-on codes(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using 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.

Medicare defines on the Medicare Physician Fee Schedule Data Base (MPFSDB) those services for which co-surgeons may be recognized. Co-surgery is generally performed by physicians of different specialties.

The three classifications for co-surgery :

Surgeries reported in the MPFSDB with a “1” in the co-surgery field may be paid as co-surgery but require documentation to support the medical necessity for the two surgeons. For electronic claims, submit the operative report via the fax documentation process, if available in your area. If not available, reports will be requested. For paper claims, submit the operative report as an attachment to the Form CMS-1500.

Surgeries that may be paid as co-surgery, but do not require documentation if the two specialty requirement is met are identified in the MPFSDB with a “2” in the co-surgery field.

Modifiers Billing Guide

Procedures which may not be billed as co-surgery are listed in the MPFSDB with co-surgery indicators of "0" or "9".

Reimbursement of medically necessary co-surgeon services is equal to 50% of 125% (or 62.5% of the Medicare Fee Schedule allowance for each physician) as indicated in the following example:

Medicare Fee Schedule	\$ 1000.00	\$ 1000.00
Multiplied by 1.25	<u>x 1.25</u>	<u>x .625</u>
Equals Total Allowance (for both Physicians)	\$ 1250.00	
Allowance for Each Physician (divided by 2)	\$ 625.00	\$ 625.00

- 66 Surgical team: Under certain circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of modifier -66 to the basic procedure number used for reporting services.

Note: CMS defines on the MPFSDB those services for which Contractors may permit team surgeons, not permit team surgeons, and permit team surgeons if supporting documentation establishes medical necessity. Reimbursement of medically necessary surgical team services for each physician who reports modifier -66 is made on a claim-by-claim basis and requires an operative report.

If two physicians were each performing a different procedure during the operative session each physician would bill independently for only the procedure he/she actually performed, even if the procedures are performed through the same incision. Multiple surgery rules would not apply unless one or both of the surgeons actually performed multiple procedures.

Special Note: Generally payment for an assistant surgeon is not made in addition to reimbursement for two surgeons (modifier -62) or team surgeons (modifier -66). Medical documentation must substantiate the necessity.

Repeat Procedures

- 76 Repeat Procedure or Service by Same Physician: It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service.

Modifiers Billing Guide

Use this modifier to indicate that a repeat procedure was necessary and that it does not represent a duplicate bill for the original surgery or service on the same date. An explanation of the medical necessity for the repeat procedure is necessary, (e.g., repeat x-ray performed after thoracotomy tube placement).

This modifier may be submitted with multiple EKG interpretations performed for the same patient on the same date of service, to distinguish these services from duplicate billing situations. Submit the time each service was performed.

-77 Repeat Procedure by another Physician: The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier -77 to the repeated procedure or service.

An explanation of the medical necessity for the repeat service is necessary. It may be entered in Item 19 of the Form CMS-1500 or the comment field of the electronic version.

-78 Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period: It may be necessary to indicate that another procedure was performed during the postoperative of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first and requires the use of an operating or procedure room, it may be reported by adding the modifier -78 to the related procedure. (For repeat procedures see modifier -76).

Services submitted with this modifier will be reimbursed at the intra-operative percentage of the global surgery allowance for the procedures with 010 or 090 days postoperative periods.

Procedures with 000 global surgery days are allowed the full value for the procedures since these procedures do not have pre, postoperative or intra-operative values.

Unrelated Surgical Service

-79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by adding modifier -79. (For repeat procedures on the same day see modifier -76).

A different diagnosis would generally be reported. Failure to use modifier -79 when appropriate may result in denial of the subsequent surgery.

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

Note: The use of **RT** and **LT** modifiers, or other descriptive modifiers when the diagnosis is the same, is helpful and should be used **following** Modifier **-79**, **not** in place of it.

Modifiers Billing Guide

Example:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)												
1. 743 33												
2. _____												
3. _____												
4. _____												
24. A.	DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES			E.
	From		To			PLACE OF	EMG	(Explain Unusual Circumstances)			DIAGNOSIS	
	MM	DD	YY	MM	DD	SERVICE		CPT/HCPCS	MODIFIER		POINTER	
1	05	01	2007	05	01	2007	22		66984	LT		1
2	06	01	2007	06	01	2007	22		66984	79 RT		1
3												

The second procedure was performed within 30 days of a procedure that has a 90 day follow-up, but is not related to the first procedure.

For additional information:

CMS Pub 100-04, chapter 13, section 100.1,

<http://www.cms.hhs.gov/manuals/downloads/clm104c13.pdf>

CMS Pub 100-04, chapter 23, in the Addendum following section 90

<http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf>

Unusual Circumstances

- 22 Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier -22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient’s condition, physical and mental effort required).
 - Application of modifier 22 only applies to those procedures that have global periods of 0, 10, or 90 days. This includes those services usually classified as therapeutic or diagnostic rather than surgical.
 - When using this modifier, always include a report or other narrative statement that is concise and illustrates how the complexity of the procedure differs from that usually performed. If no documentation is submitted or the documentation is insufficient, payment will be based on fee schedule pricing.
 - This modifier should not be used with an E/M service.

- 51 Multiple Procedures: When multiple procedures, other than E/M services, physical medicine and rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated “add-on” codes.

Modifiers Billing Guide

Modifier 51 need not be reported to Medicare. The Contractor will add if appropriate.

- The Medicare standard payment rules for most multiple procedures allow reimbursement for the procedure with the highest value at 100 percent of the fee schedule and 50 percent allowance up to the fifth procedure. Each procedure after the fifth requires a report and is subject to review.
- 52 Reduced Services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
- Medicare requires an operative report for surgical procedures and a statement as to how the reduced service is different from the standard procedure whether or not the service is a surgical procedure.
 - For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifier 73 and 74. See modifiers approved for ASC hospital outpatient use.
- 53 Discontinued Procedure: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may necessary to indicate that a surgical or diagnostic procedure was started but discontinued. These circumstances may be reported by adding modifier -53 to the code for the discontinued procedure.
- An operative report is required as well as a statement as to how much of the original procedure was accomplished, with the exception of those codes listed in the fee schedule with an allowance for the procedure with a modifier 53.
 - This statement may be entered in the comments field or submitted via the fax documentation process for electronic claims (in areas where fax documentation is allowed).
 - For paper claims, this documentation must be submitted as an attachment to the Form CMS-1500

Note: This modifier is not to be used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

*Ambulatory Surgical Centers, see modifiers -73 and -74.

TEACHING PHYSICIAN

- GC This service has been performed in part by a resident under the direction of a teaching physician
- Use of this modifier certifies that a teaching physician was present during the key portions of the service and was immediately available during the other parts of the service.
- GE This service has been performed by a resident without the presence of a teaching physician under the primary care exception
- This modifier is informational and may only be submitted with procedure codes included in the “primary care exception”:
 - HCPCS code G0344
 - CPT codes 99201-99203, 99211-99213
 - CPT code 93005 and 93041
- 82 Assistant surgeon (when qualified resident surgeon not available)
- The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 with a surgical procedure code number.
 - This modifier may only be submitted with surgery codes.
 - No additional documentation is required with the claim when CPT modifier 82 is submitted.
 - Documentation must be maintained in the patient’s medical record:
 - A statement that no qualified resident was available to perform the service, or
 - A statement indicating that exceptional medical circumstances exist, or
 - A statement indicating the primary surgeon has an across the board policy of never involving residents in the preoperative, operative or postoperative care of his/her patients.

To determine whether the services of an assistant surgeon may be submitted to Medicare with CPT modifier 82, refer to the Medicare Physician Fee Schedule database (MPFSDB)

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

For additional information refer to CMS Pub. 100-02, Chapter 15, Section 30

<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>

CMS Pub. 100-02, Chapter 12, section 100

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

<http://www.cms.hhs.gov/MLNProducts/downloads/gdelinesteachgresfctshst.pdf>

TECHNICAL & PROFESSIONAL COMPONENTS (RADIOLOGY AND PATHOLOGY)

Only certain services include a technical and professional component. Your Medicare Fee Schedule includes separate allowances for these services.

-TC Technical component. Under certain circumstances, a charge may be made for the technical components alone. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number.

Modifier TC identifies those situations where the physician performs the test but does not interpret the results.

Modifier -TC should not be used if there is a specific code that describes a procedure that is 100% technical (has no professional component). For example, it would be inappropriate to use modifier -TC in conjunction with CPT code 93005 (electrocardiogram, routine ECG with at least 12 leads; tracing only, **without interpretation and report**).

-26 Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier -26 to the usual procedure code.

Use modifier 26 when a physician interprets but does not perform the test. Modifier -26 should not be used if there is a specific code that already describes only the physician component of a given service. For example, it would be inappropriate to use modifier -26 in conjunction with procedure 93010 (electrocardiogram, routine ECG with at least 12 leads; **interpretation and report only**) because it is 100% professional.

-GG Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day.

NOTE: Modifier GG should be used to show that the diagnostic test performed on the same date as the screening test is appropriate. This modifier is for tracking purposes only.

For additional information refer to the Preventive Services Billing Guide

<http://www.medicarenhic.com/providers/pubs/preventgd.pdf>

WAIVER 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.

ABN Modifiers

-GA Waiver of liability statement on file

When services are denied as not being reasonable and necessary, the beneficiary is not responsible for payment of the service unless, prior to the service being rendered:

- he/she has been notified in writing that Medicare will likely deny payment of the service/procedure for their specific condition; and
- the beneficiary has signed the agreement stating they will assume financial responsibility for payment of the service.

The reason given must be specific to the service(s) under consideration. A routine notice and/or a notice that only states a denial is possible is not acceptable. An ABN is not appropriate for Medically Unlikely Edit (MUE) denials.

All providers are required to use the CMS ABN form, available on the CMS website at http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp.

The ABN form must be presented to the patient before the service or procedure is initiated. While the ABN form need not be submitted with the claim, a copy of the signed document must be maintained with the patient's medical record and available upon request.

-GY Item or services statutorily excluded, does not meet the definition of any Medicare benefit

It is recognized that most non-covered services are typically billed to Medicare for denial purposes only and then submitted to the patient's secondary insurance for consideration. The -GY modifier must be used when physicians, practitioners, or suppliers want to indicate that the

Modifiers Billing Guide

item or service is statutorily non-covered (as defined in the Program Integrity Manual (PIM) Chapter 1, §2.3.3.B) or is not a Medicare benefit (as defined in the PIM, Chapter 1, §2.3.3.A)

- Examples of services for which HCPCS modifier –GY may be appropriate include: routine physicals, laboratory tests in absence of signs or symptoms, and hearing aids.
- Services which are statutorily excluded, or considered not a benefit of Medicare can be identified by reviewing the Medicare Physician’s Fee Schedule Data Base (MPFSDB). Non-covered services can be identified with a status indicator of N (Non-covered service.) To locate services that have a MPFSDB indicator of “N”, please see the following CMS

Website:

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/itemdetail.asp?filterType>

Select the PFS Relative Values Files for the year in question, then download item RVU073A and then select the PPRRVU07.xls file (or 08, as appropriate) from your list of files. This will open up an excel spreadsheet which you can then sort to find all the services with a status “N”.

- You may offer the patient a Notice of Exclusion from Medicare Benefits (NEMB) form. This form is *optional* and is available on the CMS website at .
http://www.cms.hhs.gov/BNI/11_FFSNeMBGeneral.asp

-GZ Item or service expected to be denied as not reasonable and necessary – (No ABN on File)

Both Medicare beneficiaries and providers have certain rights and protections related to financial liability under the Fee-for-Service (FFS) Medicare and Medicare Advantage Programs. These financial liability and appeals rights and protections are communicated to beneficiaries through notices given by providers.

- Submit modifier –GZ when there is no valid Advance Beneficiary Notice (ABN) on file for the service.
- Modifier GZ should not be submitted with services that are statutorily excluded. Refer to modifier –GY for these services.
- For more information regarding ABNs used with ambulance services, refer to:
<http://www.cms.hhs.gov/AmbulanceFeeSchedule/downloads/ambabn71603.pdf>

MISCELLANEOUS SERVICES

-32 Mandated Services: Services related to mandated consultation and /or related services (eg, third-party payer, governmental, legislative or regulatory requirement)

- This modifier is not used by Medicare.

-99 Multiple modifiers: Under certain circumstances two or more modifiers may be necessary to completely delineate a service.

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- Although the current CPT manual specifies that CPT modifier -99 may be used when it is necessary to indicate more than 2 modifiers on a single detail line or service, Form CMS-1500 (05/06) allows the use of up to **4 modifiers**.
- If more than 4 modifiers are required, the appropriate format is to place modifiers with major importance in the first three positions, then modifier 99 in the fourth. In Item 19 or the comments field, indicate
 - line 1 = AA BB CC DD EE.
- Electronic claims: submit the specific modifiers represented by modifier 99 in the comments field.
- Paper claims: submit the 5 or more additional modifiers in Item 19 of the CMS-1500 claim form.

-CC Procedure code changed

- Used by the Medicare contractor when procedure code submitted was changed either for administrative purposes or because an incorrect code was filed. **Providers should not use this modifier for billing.**

-GJ “Opt Out” physician or practitioner provided emergency or urgent service

- Physicians that have opted out of Medicare (also called “private contracting”) are not permitted to submit services to Medicare. The exception to this rule is when services are provided on an emergent or urgent basis. Opt-out physicians and practitioners must submit these services to Medicare with HCPCS modifier GJ.
- In order to opt out of Medicare, physicians and practitioners that are permitted to opt out must follow certain procedures and guidelines.

For more information: <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> or refer to the Provider Enrollment section of the NHIC website.

-GT Via interactive audio and video telecommunications systems

This modifier may be submitted with “telehealth” services. Generally, interactive audio and video communications must be used to permit real-time communication between the distant site physician/practitioner and the Medicare beneficiary. The patient must be present and participating in the telehealth visit. The only exception to the “real-time” communication requirement is for Federal demonstration projects conducted in Alaska and Hawaii. For services provided in Alaska and Hawaii, refer to HCPCS modifier GQ

-GQ Via asynchronous telecommunications systems

This modifier may be submitted with “telehealth” services. Generally, interactive audio and video communications must be used to permit real-time communication between the distant site physician/practitioner and the Medicare beneficiary. The patient must be present and participating in the telehealth visit. The only exception to the “real-time” communication

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requirement is for Federal demonstration projects conducted in Alaska and Hawaii. For services provided in states other than Alaska or Hawaii, refer to HCPCS modifier GT.

-LT Left Side

Used to identify procedures performed on the left side of the body.

-RT Right Side

Used to identify procedures performed on the right side of the body.

MODIFIER ORDER

The positioning of modifiers following the procedure codes aids in correctly processing services. For example, modifier -80 is necessary to identify a service as an assistant surgeon, and should be used in the first position. Other modifiers are exception modifiers, and tell the system to overlook the rule in this case, such as in NCCI editing.

The modifiers should be in the first or second position whenever possible

- E1, E2, E3, E4, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, GN, GO, GP, LC, LD, LR, LT, QA, QR, QV, Q3, RC, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, 22, 24, 25, 50, 55, 59, 76, 80, 81, 90, 91, 99
- These modifiers must remain on the detail line in the remaining fields
AK, GA, GB, Q4,

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 (formerly Local Medical Review Policies) 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:

New England

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 Part B Contractor for Maine, Massachusetts, New Hampshire, 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;
- 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 the Benefits Integrity Safeguard Contractor.

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

Modifiers Billing Guide

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

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)

All States

1-888-248-6950

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 - Thursday

10:00 a.m. to 4:00 p.m. Friday

All States

1-866-801-5304

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
Vermont	P. O. Box 7777 Hingham, MA 02044
Rhode Island	P.O. Box 9203 Hingham, MA 02044
EDI (Electronic Data Interchange)	P.O. Box 9104 Hingham, MA 02044
Written Correspondence	P.O. Box 1000 Hingham, MA 02044
Redetermination	P.O. Box 3535 Hingham, MA 02044
Medicare Reopenings **See note below	P.O. Box 3535 Hingham, MA 02044
Medicare B Refunds	Medicare B Accounting Control P.O. Box 9103 Hingham, MA 02044
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

** Reopening requests only 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

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 (NE Updates, EDI, etc.) will be sent out on an as-needed basis.

Provider Page Menus/Links

From the home page, click the "New England Providers" link. This will take you 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 Hearing (CMS 1965)
- 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/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	3/6/08	Brenda Bedard	Michele Kelly	New Guide
2.0	10/1/08	Brenda Bedard	Mylene Clark	Annual Review. Removed references to CA.
3.0	6/12/09	Brenda Bedard	Mylene Clark	Annual Review. Correct spelling, updated phone numbers and mailing addresses.

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>