Webinar
April 23, 2008
"Bundled Services"
Educational Tools, Questions & Answers

Bundled Services

Correct Coding Errors continue to be among the top billing issues. Correct coding can involve a wide range of issues. Correct Coding denials based upon the National Correct Coding Initiative (NCCI) edits and global surgery rules can be identified by the following message on the Standard Paper Remittance (SPR):

SPR Message

- B15 – "Claim/service denied/reduced because this service/procedure is not paid separately"

National Correct Coding Initiative (NCCI) Edits

The CMS developed the Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

The purpose of the CCI edits is to ensure the most comprehensive groups of codes are billed rather than the component parts. Additionally, CCI edits check for mutually exclusive code pairs. These edits were implemented to ensure that only appropriate codes are grouped and priced.

The following is an example of the NCCI edits:

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
35982	99205	G0117		20020101	*	0
35983	99205	G0118		20020101	*	0
35984	99205	G0120		19980401	19980401	9
35985	99205	G0245		20020701	*	0
35986	99205	G0246		20020701	*	0
35987	99205	G0248		20021001	*	1
35988	99205	G0250		20021001	*	1
35989	99205	G0270		20030701	*	0
35990	99205	G0271		20030701	*	0
35991	99205	G0272		20030101	20040331	1
35992	99205	G0363		20050701	20051231	0
35993	99205	M0064		20030401	*	0
35994	99205	P3000		19980401	19980401	9
35995	99205	P3001		19980401	19980401	9

It is extremely important to have a strong understanding of the National Correct Coding Initiative, as it can have a high impact on your claims payment and denials. Bundled codes should not be billed separately and cannot be charged to the patient. Subscribe to our website mailing list from **www.medicarenhic.com** to receive quarterly notification of updates. You can then review any possible changes for codes you frequently bill.

1st Column	(Shaded area) This is just the number (counting) of that particular edit.
2nd Column	This is a listing of " CPT/HCPCS codes. The CPT/HCPCS code listed in "COLUMN 1" is the most comprehensive code.
3rd Column	The CPT/HCPCS code in "COLUMN 2" will not be paid on the same day as the code in "COLUMN 1."
4th Column	This column lets you know if the edit was in existence prior to 1996.
5th Column	This is the effective date of the edit.
6th Column	This is the termination date of the edit (if applicable).
7th Column	This is the Modifier column.

- If a "0" is present in this column the use of a modifier will not override the NCCI edit and the code in column 2 will never be paid on the same day as the column 1 code.
- If a "9" is present in this column it means that the use of a modifier is not applicable to the code set.
- If a "1" is present in this column, the proper use of a modifier (that can be clearly identified in the medical record as separately identifiable) can override the edit.

Bundled Services/Supplies (Status B Procedures)

Bundled Services/Supplies produce a high quantity of claims denials on a regular basis. These procedures have a Medicare Physicians Fee Schedule Data Base (MPFSDB) Indicator of "B" (bundled code). Payments for these procedures are always bundled into payment for other services the same day and separate payment is never made, nor can the patient be charged for the bundled service(s). The correct coding denials based upon "B" status codes can be identified by the following message on the SPR:

- M80 – "Not payable, service part of another service performed on the same day"

The following list contains codes denied that have a MPFSDB indicator of "B". Please note that this is not an all inclusive list, but a list of the procedures with the highest volume of denials.

Procedure Code	Procedure Code Description
36416	Collection of Capillary Blood Specimen (e.g., finger, heel, ear stick)
97010	Application Hot or Cold Packs
99000	Handling A/O Conveyance of Specimen for Transfer from a Physician's Office to a laboratory
99001	Handling A/O Conveyance of Specimen for Transfer from the Patient in Other Than Physician's Office to a laboratory
A4550	Surgical Trays
99070	Supplies / Material Provided by Physician
A4649	Surgical supply; miscellaneous
99050	Service provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed in addition to basic service
99053	Service(s) provided between 10:00 p.m. and 8:00 a.m. at 24 hour facility, in addition to basic service
99024	Post operative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure

To locate other procedures that have a MPFSDB indicator of "B", please see the following CMS Website at **http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=2.**

Select the downloads item RVU07A3 and then select the PPRRVU07.xls file 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 "B".

Evaluation & Management Codes (E & M) and Drug Administration
In 2005 changes were put into effect which affected payments for E & M services when billed with non-chemotherapy and chemotherapy drug infusion codes or diagnostic or therapeutic injection codes. These changes were outlined in Change Request # 4032 and involved visit codes (99201-99215). These guidelines have caused an increase in denials of E & M codes for CCI issues. Here are some key points to remember when billing for E & M codes in conjunction with the above mentioned services.

As of January 2005, CPT code 99211 is no longer payable and will be denied for CCI when billed with non-chemotherapy and chemotherapy drug infusion codes or diagnostic or therapeutic injection codes. However, Medicare will pay for an E & M service of a higher level of complexity than a 99211 if reasonable and necessary and documented in your medical record. Modifier 25 must be appended to the E & M service to identify that a significant and separately identifiable E & M service was performed.

If the higher level E & M code is not billed with modifier 25, it will be denied for CCI. Please note, modifier 25 should only be used for E & M services in this situation when the service can clearly be identified and documented in your medical records as a separate procedure from the procedure it would have normally been bundled with. For example, a patient receives a therapeutic injection and an office visit for an unrelated issue such as high blood pressure.

You may refer to the following link for more information on this subject.
http://www.medicarenhic.com/cal_prov/articles/modifier25_0208.pdf

Lab Services
Lab services produce a high volume of CCI denials. There are a variety of codes that are billed by physician's/supplier's on a regular basis that are either part of a more comprehensive service or are codes which cannot be unbundled regardless of how the procedure is billed. *Please note, the majority of these reminders also apply to CCI denials in general and can apply to other types of services as well.*

Here are some important reminders about billing for lab services

- Always bill the most comprehensive groups of codes rather than their component parts
- Visit the CMS website at **http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/itemdetail.asp?filterType=none&filterByDID+99&sortByDID+2&sortOrder=ascending&itemID=CMS046542** regularly to determine if services hit NCCI edits, if there have been any changes to the CCI edits, or if services can be billed together. The NCCI is updated on a quarterly basis (January, April, July, October) and should be reviewed quarterly for any changes affecting your practice.
- Make note of code pairs where the modifier indicator is 0, as these service will never be paid together. Only the most comprehensive code will be paid in these circumstances and a modifier will not unbundle the two services. Some examples of code pairs that will not be paid together are 84478 and 80061, 84479 and 84439, and 80076 and 80053 (This is not an all inclusive list).
- If using modifier 59 to unbundled services, ensure that it is being used properly and not just to bypass the CCI edits. See the CMS website at **http://www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf** for modifier 59 usage guidelines. You can also refer to **http://www.medicarenhic.com/providers/articles/ccimodifiers_1207.pdf** for information on the use of other modifiers with CCI edits.

  - Remember that any time you use modifier 59 or any other modifier to by-pass the CCI edits, your medical records must fully describe and support that the service was a significant and separately identifiable service for which reimbursement can be requested.

Some of the most common laboratory CPT codes denied because the service is not paid separately are:

Procedure Code	Procedure Code Description
83721	Lipoprotein, direct measurement: LDL cholesterol
84479	Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio
84436	Thyroxine, total
84478	Triglycerides

Global Surgery
Global surgery denials are one of the top claim submission errors. The global surgery claim adjustment reason code listed on the Electronic Remittance Advice (ERA) or Standard Paper Remittance (SPR) Advice Notice is:

- CO97 - "Payment is included in the allowance for another service/procedure".

Data analysis reveals the majority of the global surgery denials are evaluation and management services billed within the global surgery period.

A global surgical fee includes *all* necessary services performed by the physician before, during, and after a surgical procedure, including care due to complications from the surgery. The term surgery or service includes therapeutic injections and wound repairs. *All* HCPCS in the range of 10000 to 69999 are subject to global surgery rules. Diagnostic services within other sections may also be subject to global surgery rules.

To avoid global surgery denials:
Determine the global period for surgical procedures; zero, ten, or ninety days. Refer to the Medicare Physician Fee Schedule Look-up located on the CMS website at:
http//www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=2.

Select the downloads item RVU07A3 and then select the PPRRVU07.xls file from your list of files.

- Global periods of zero or ten follow up days are considered minor surgeries.
- Global period of ninety follow up days is considered major surgery.
- Monitor services provided to patients that receive surgical procedures
- Use modifiers to report *unrelated or exception* services within a global period.

If it is determined the E&M service is not related to the surgical procedure or is above and beyond the usual service, you must bill the claim with the appropriate modifier.

Global surgery modifiers to use with evaluation and management services are:
24 – Unrelated E&M Service by the Same Provider during a Postoperative Period
Modifier 24 was intended for use with services that are absolutely unrelated to the surgery. When using modifier 24, ensure that the patient's records and ICD-9-CM codes recorded on the claim clearly indicate that the E&M visit is unrelated to the original procedure.

25 – Significant, Separately Identifiable E&M Service by the Same Provider on the Same Day.
The additional E&M service must be *separately identifiable* from the surgical procedure and require significant effort **above and beyond** the usual pre and postoperative service routinely required for the procedure. The term separately identifiable means an additional service is not part of the surgery or procedure. Separately identifiable services are considered exceptions to the global surgery policy and must be identified with a modifier.
Different diagnoses are not required for reporting of the E&M services on the same day. However, the patient's records must contain sufficient information to support the use of modifier 25.
NOTE: The most common cause for claim denial of an unrelated E&M service billed on the same day as another procedure is due to the omission of Modifier 25.

57 – Decision for Major Surgery
An E&M examination coded with modifier 57 indicates a visit that resulted in the initial decision to perform a major surgery. It is used the day before or the day of major surgery. Surgeries that have a 90 day follow-up period are considered major surgeries. When coding modifier 57 ensure that the patient's records clearly indicate when the initial decision to perform the surgery was made.
Do not use modifier 57 with an E&M service performed on the same day as minor surgery.

For additional information on bundled services refer to the General Surgery Guide on the NHIC website at:**http://www.medicarenhic.com/providers/pubs/surgeryguide.pdf**

The Physician Fee Schedule on the CMS website at: **http://www.cms.hhs.gov/PhysicianFeeSched/**

Example Questions:
Question:
“Can a surgeon bill for a readmission (99221, 99222 or 99223) in the global period due to a complication from the surgery he performed? For example, surgeries with a 90 day global. An Appendectomy (44950) or a Colectomy (44140).”

Answer:
The surgeon cannot re-bill for a readmission (99221,99222 or 99223) in the global period due to complications of a surgery that he performed before. Referencing from our IOM (Internet Only Manuals) the following may assist.

30.6.8 - Payment for Hospital Observation Services

A. Subsequent Hospital Visits During the Global Surgery Period
(Refer to §§40-40.4 on global surgery)
The Medicare physician fee schedule payment amount for surgical procedures includes all services (e.g., evaluation and management visits) that are part of the global surgery payment; therefore, contractors shall not pay more than that amount when a bill is
fragmented for staged procedures.

Here is an example:
A patient at the 20th day following a resection of the colon is admitted to observation for abdominal pain by the surgeon who performed the surgery. The surgeon determines that the patient requires no further colon surgery and discharges the patient. The surgeon may not bill for the observation services furnished during the global period because they were related to the previous surgery. You can also refer to the IOM (Internet Only Manual) Chapter 100-04 section 40.3 - Claims Review for Global Surgeries

Question:
“After a hysterectomy, is consultation re: hormone therapy (use or not, risks, etc) billable or is it part of global surgery?”

Answer:
The consultation/office visit is considered postoperative care and the visit is already included in the global surgery rules. A hysterectomy is considered a major surgery with a 90 day global period.

For more information on Global Surgery rules may visit the CMS website at this following link:
http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf

Reference: Chapter 100-04 section 40.1 - Definition of a Global Surgical Package

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