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NGS PROVIDER EXPERIENCE
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Reducing Unprocessable Claim Rejections

6/27/2023

NGSMU
NGS Medicare University
Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

1773_0623

Today's Presenters

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  - Provider Outreach and Education Consultant
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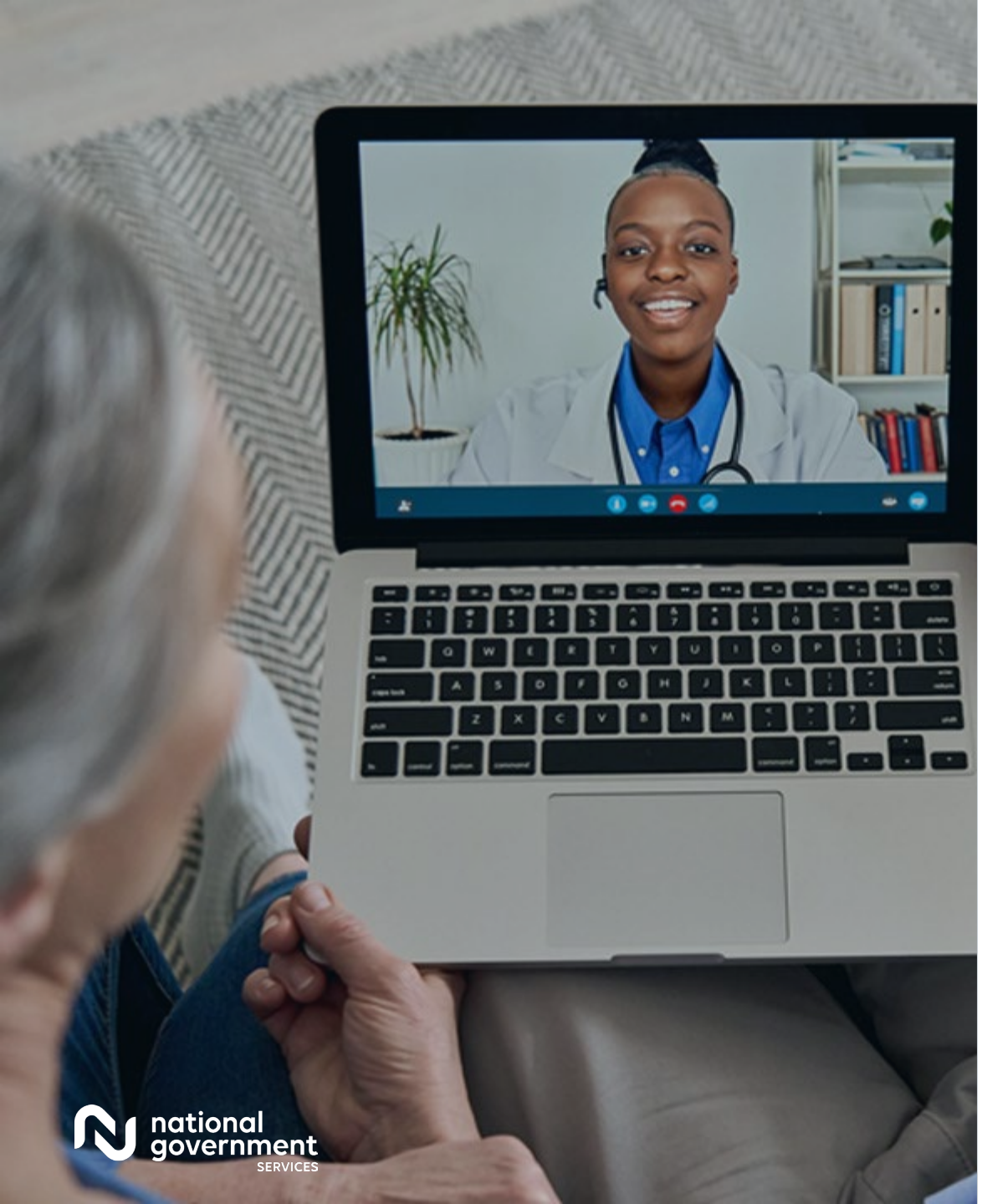

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Objective

After today's session, you'll understand the importance of submitting a claim the first time with all the required facts for NGS to process the claim.

Agenda

- Claim Requirements
- Remittance CARC and RARC
- Beneficiary Eligibility
- Provider Information
- CPT, HCPCS, and Modifiers

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Claim Requirements

- If claims do not conform to NGS specifications, they will be returned
- NGS' initiative is to reduce the number of unprocessable claims
- Goal is to get your claims accurately processed the first time

Unprocessable Claims

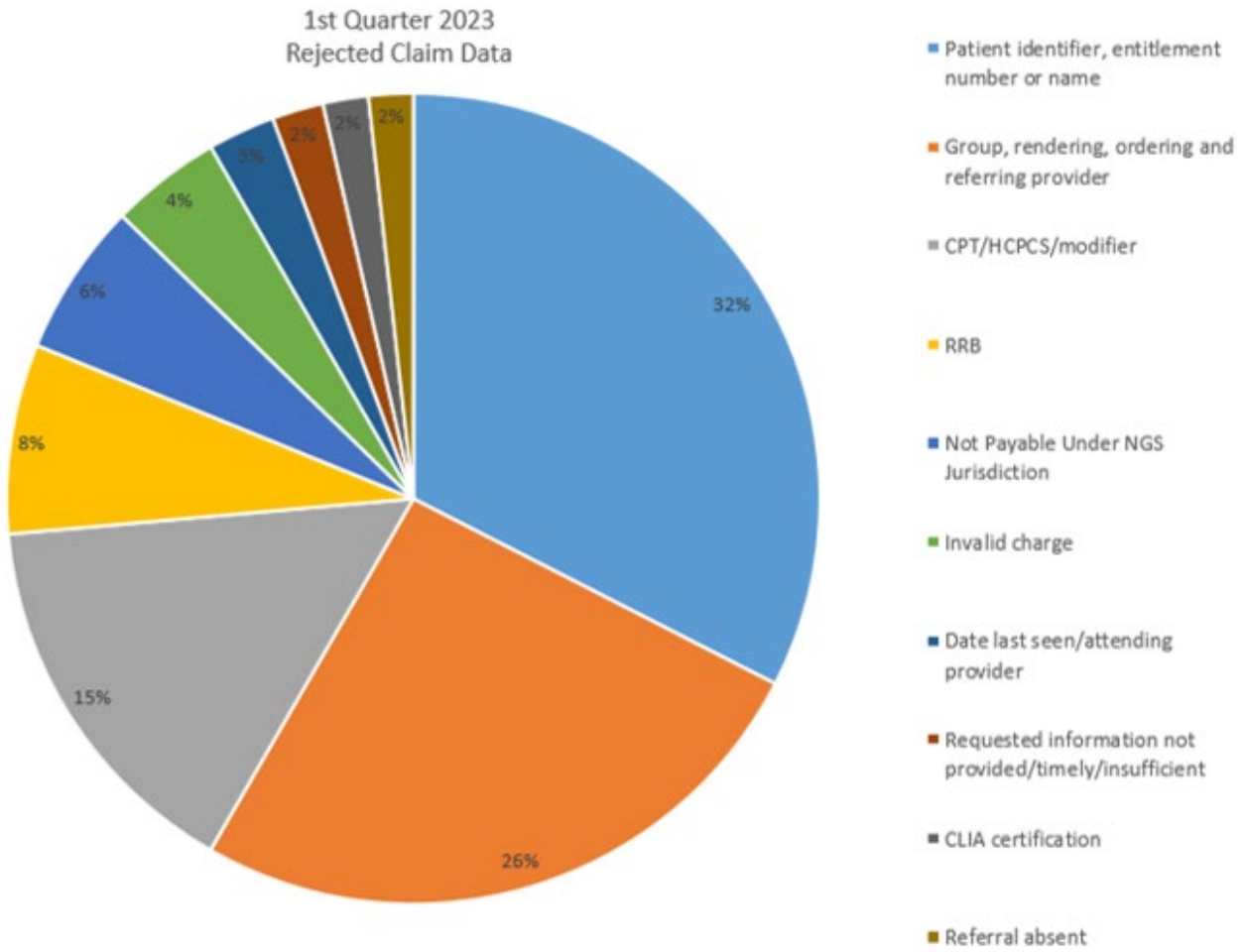
- Information is
  - Invalid
  - Missing
  - Insufficient
  - Incomplete
- Claims will be rejected
- Must submit a new claim
- No appeal rights granted

- Methods for rejection
  - Remittance advice shows an MA130
  - Additional remark codes used to identify the error
- Paper claims are screened
  - Form letter sent back indicating the error
- Electronic claims
  - Fail initial edits

Remittance Example and References

Code	Description
CO-16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Additional information is supplied using remittance advice remarks codes. Note: Refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment Information REF)
MOA Code MA27	Missing, incomplete or invalid entitlement number or name shown on the claim submitted
WPC References	• X12 Claim Adjustment Group Codes • Remittance Advice Remark Codes Reference • Claim Adjustment Reason Code Reference

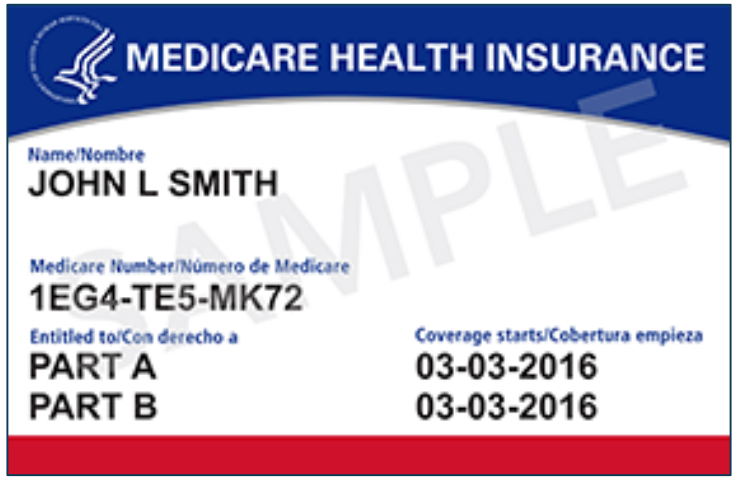
Q1 2023 Claim Rejection Data



Reducing Claim Rejections for Beneficiary Eligibility

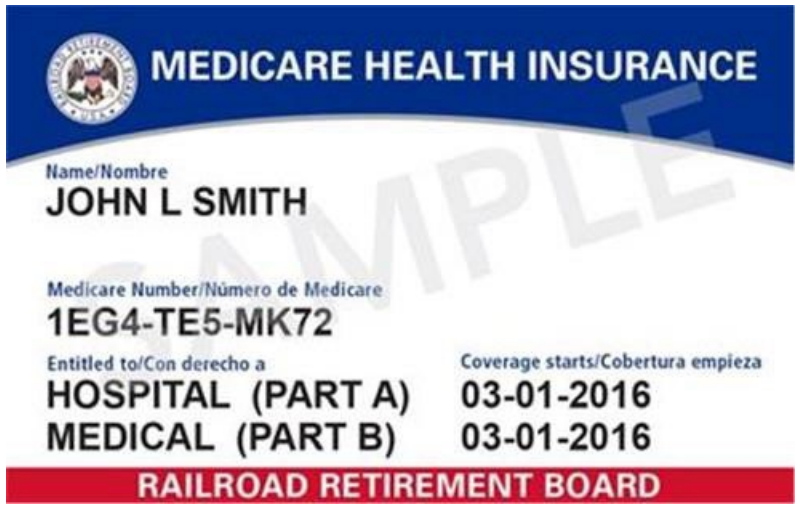
Traditional Beneficiary Eligibility

- PR-31
  - Name or MBI was incorrect or missing
  - Date of death precedes date of service
  - Expenses incurred prior to coverage or after coverage terminated
  - Not covered by Medicare at time patient received services



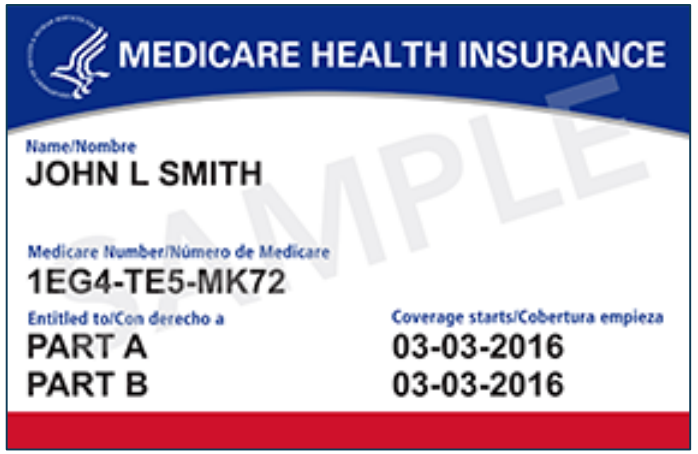
Railroad Retirement Board Eligibility

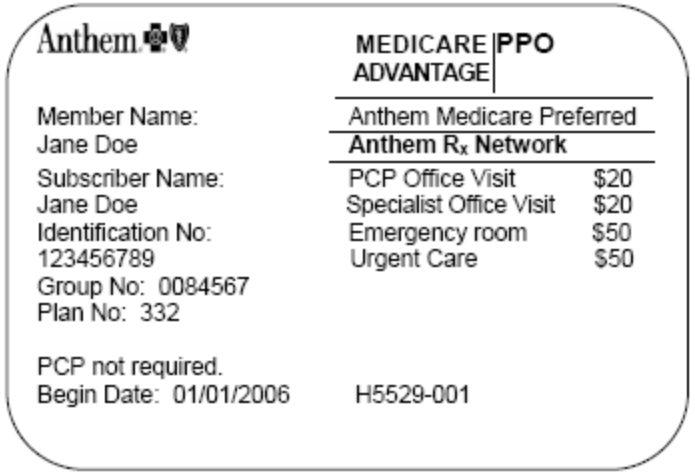
- N105
- Misdirected claim for RRB beneficiary
- Submit claims to the RRB carrier
  - Palmetto GBA
    P.O. Box 10066
    Augusta, GA 30999
    866-749-4301



Medicare Advantage Eligibility

- OA-109
  - Yearly open enrollment
    - ✓ Usually October 15th–December 7th
- Private health plans for members' health care and claims must be sent to MA plan
- Screen beneficiaries
- Provider self service
  - IVR or NGSConnex





Interactive Voice Response

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Interactive Voice Response Touch-Tone Instructions

Tips for Sucessful Touch Tone Use

1) You cannot combine speech and touch-tone when providing a single element (e.g., you cannot speak the numbers in an Medicare Beneficiary Identifier (MBI) and then enter the alpha character(s) via touch-tone). However, you can switch between speech and touch-tone throughout the call (e.g., speech for beneficiary name and touch-tone for MBI).
2) There is no need to wait for a prompt to try touch-tone.
3) You are able to press "9" to move to the next topic.

Visit www.NGSMedicare.com for interactive voice response (IVR) telephone numbers and complete touch-tone instructions.

Using The IVR Conversion Tool

Visit www.NGSMedicare.com > Provider Resources > Calculators & Tools > Interactive Voice Response Conversion Tools to easily convert the name, Provider Transaction Access Number (PTAN), Medicare numbers (MBI), etc. to touch tone for easy input into the IVR system.

Alpha-Only Touch Tone Entries

When speaking the beneficiary's name the IVR requires First Name, Last Name. However, when using touch-tone, the IVR requires Last Name, First Initial. For names, you only have to press the button on a telephone keypad that corresponds with the letter. Below are some examples:

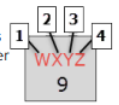
Beneficiary Name	Converted Name	Touch Tone
John Doe	DOEJ	3635
John St. Doe	STDOEJ	783635
John Doe Jr.	DOEJRJ	363575
John L. Doe Smith	DOESMITHJ	3637648 45

296_0722

Alpha-Numeric Touch Tone Entries

Use this function to enter elements that contain both alpha and numeric characters.

Each button on a telephone keypad has a corresponding set of letters. Each letter is identified as a 1, 2, 3 or 4 to indicate the position on that key.



To enter a letter, you will need to press a combination of buttons on your telephone keypad.

First, press the * key. Then, press the key the letter appears on. Lastly, press the key corresponding to the position of the letter on that key. Below are some examples:

Alpha-Numeric Example	Touch Tone Entry
123456789B	1 2 3 4 5 6 7 8 9 *2 2
1EG4TE5MK72	1* 3 2* 4 1 4* 8 1* 3 2 5* 6 1* 5 2 7 2
Q5W5Z5	*1 1 5* 9 1 5* 1 2 5

Touch Tone Combinations for Letters

Letter	Press	Letter	Press
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*72
E	*32	R	*73
F	*33	S	*74
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*94

Medicare IVR Eligibility Check List

Please remember to have your NPI and PTAN and last five digits of your TIN available.

MBI:_____
Patient's First Name: _____ DOB: _____
Patient Last Name: _____
Part A: Effective:_____ Termed:_____
Part B: Effective:_____ Termed:_____
MSP Type:_____ Name:_____
Effective: _____ Termed: _____
Medicare Advantage (MA) Plan #:_____
Name:_____
Address:_____
Phone: _____
Effective: _____ Termed: _____
Last Billing Date: _____
Hospital Full Days:_____ Coinsurance Days:____
SNF Full Days:_____ Coinsurance Days:____
Lifetime Reserve Days: _____
Part B Deductible: _____
This year: _____ Last year: _____
Physical Therapy Limits:
This year: _____ Last year: _____
Occupational Therapy Limits:
This year: _____ Last year: _____
Home Health Name:_____
Address:_____
Effective: _____ Termed: _____
Hospice Name: _____
Address:_____
Effective:_____ Termed: _____

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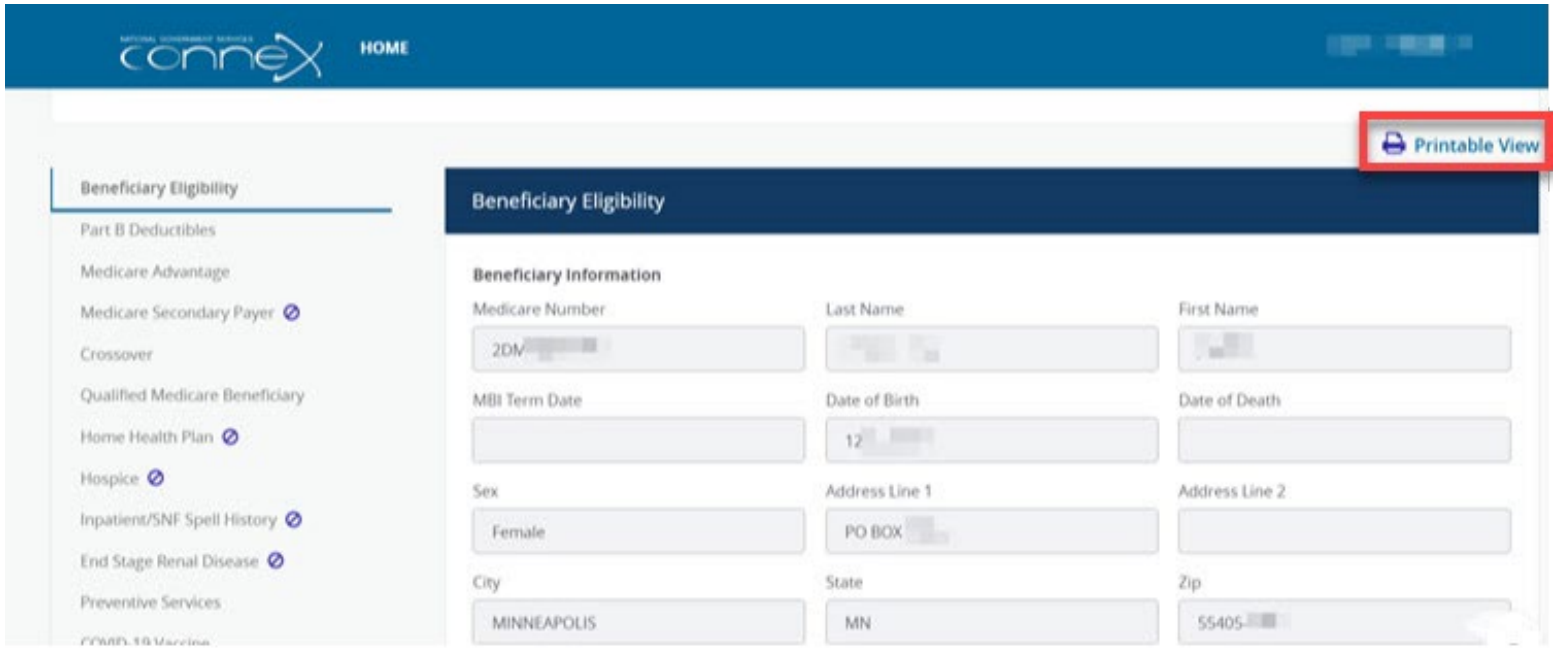
NGSConnex Beneficiary Eligibility Verification Requirements

- Four beneficiary data elements required
  - Last name
  - First name or initial
  - MBI
  - Date of birth



Steps to Successfully Check Eligibility

- Collect all insurance data from beneficiary
- Use our Interactive Voice Response System
- Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont
  - 877-869-6504
- Illinois, Minnesota, Wisconsin
  - 877-908-9499
- NGSConnex

Reducing Claim Rejections for Provider Information and Data

Ordering and Referring Provider Information

- N264, N265, N285, N286 provider name and NPI
  - Provider who orders item or services
  - Provider who requests an item or service
    - ✓ Clinical laboratories
    - ✓ Diagnostic imaging
- Missing, incomplete or invalid provider identifier
  - Line items 17 and 17b or electronic equivalent
  - No nick names
  - First and last name as it appears in PECOS
    - ✓ Ordering = DK
    - ✓ Referring = DN
    - ✓ Supervising = DQ

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
17	Name of Referring physician or other source	2310A	NM103 (DN)	Referring provider last name	Required if claim involved a referral or services were ordered. When reporting the provider who ordered services such as diagnostic and lab utilized the Referring Provider Name (2310A) loop at the claim level. Required if a service or supply was ordered by a provider and that provider is a different entity than the rendering provider for this service line. When a claim involves multiple referring and/or ordering physicians, a separate claim must be billed for each ordering/referring physician.
			NM104	Referring provider first name	
			NM105	Referring provider middle name	
		2420F**	NM103 (DN)	Referring provider last name	
			NM104	Referring provider first name	
			NM105	Referring provider middle name	
	Name of Ordering physician	2420E	NM103 (DK)	Ordering provider last name	
			NM104	Ordering provider first name	
			NM105	Ordering provider middle name	
17a	Other ID number of Referring physician				
17b	NPI	2310A	REF02 (1C)	Referring provider primary ID	
			REF02 (1C)		Enter "XX" in the NM108 to indicate an NPI is present in the NM109. Enter the NPI of the referring/ordering physician listed in Item 17
			REF02 (1C)	Ordering provider primary ID	

Billing Provider Information

- Individual or Organization billing provider data
  - Type 1 (Individual)
  - Type 2 (Organization)
- Medical group or other entity entitled to bill and receive payment for physician services
  - Each physician/NPP rendering services under the group will be identified in 24J
- Line Item 33 or electronic equivalent
  - Billing provider

Steps to Successfully Check Provider Data

- Data Files for Ordering and Referring
- National Plan & Provider Enumeration System
- Medicare Place of Service Code Set and Descriptions
- CMS-1500 Claim Form
- Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

Place Where Services Were Furnished

Place Where Services Were Furnished

- Outside Lab?
  - YES - indicates that an entity other than the entity billing performed the diagnostic test
  - Enter the charge
  - NO - indicates there are no anti-markup test
- When billing for multiple anti-markup tests, each test shall be submitted on a separate claim form
- Multiple anti-markup tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations
- In addition to Item 20 or the electronic equivalent complete
  - Item 24J with the rendering provider of the billing group
  - Item 32 with the complete name, address and the NPI of the provider the tests were purchased from
  - Item 33 with the billing provider

Steps to Successfully Check Place Where Services are Rendered

- CMS-1500 Claim Form Completion Instructions
    - Anti-markup diagnostic tests
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapters 1, 23 and 35

Reducing Claim Rejections for Invalid Billed Charges

Invalid Charges

- Each line submitted should have valid charge
- If there are no cents in charge amount, enter 00
- Codes with a zero charge used for reporting purposed may be billed with a 0.01
- Total charges in line Item 24F or electronic equivalent
- Multiple claim forms with “continued…” or “see next page” or single total in Item 28 for multiple claim forms will be returned as unprocessable

Steps to Successfully Check Billed Charges

- CMS-1500 Claim Form Completion Instructions
- Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

Reducing Claim Rejections for Date Last Seen and Attending Physician

Date Last Seen and Attending Physician

- Routine foot care
  - CPT/HCPCS G0127, 11055, 11056, 11057, 11719, 11720 and 11721
  - Certain conditions require a patient to be under the care of a primary physician
    - ✓ Claims must indicate the date last seen and NPI of attending physician
    - ✓ Line item 19 or electronic equivalent
  - Systemic condition modifiers: Q7, Q8 or Q9

Reducing Claim Rejections for Absent Referral

Certifying Physician/NPP

- Outpatient Physical and Occupational Therapy Services
  - Patients must be under the care of a physician/NPP
  - Claims must list the name and NPI of the certifying physician/NPP
    - ✓ Line item 17 (or electronic equivalent) - Provider's first name, last name as it appears in PECOS and one qualifier identifying the physician/NPP's role (DN, DK, DQ)
    - ✓ Line item 17b (or the electronic equivalent) - NPI
- Reminder
  - Include an appropriate modifier to indicate the patient was under a therapy plan of care
    - ✓ GO - Services delivered under an outpatient occupational therapy plan of care
    - ✓ GP - Services delivered under an outpatient physical therapy plan of care

Steps to Successfully Check LCDs

- Referral, DLS and NPI of attending physician requirements
    - CMS-1500 Claim Form Completion Instructions
- Routine foot care L33636/A57759
- Physical therapy L33631/A56566
    - Local Coverage Determinations

Reducing Claim Rejections for Additional Development Request

Additional Documentation Request

- NGS may need to analyze claims to determine allowance
  - Claim ADR letters
  - Common error among providers is submitting claims without documentation
  - Modifier examples: 22, 52, 53, 62, 66, NOC and unlisted codes
- Medical Review ADR letters
  - ADR letters will be generated
  - NGS requires clarification or documentation
    - ✓ If documentation is not submitted, claim rejects as unprocessable
  - Avoid this by utilizing ANSI electronic attachments program

Steps to Successfully Check Additional Documentation Request

- Additional Development Request Letters Guide
  - Ways to Respond to ADRs
  - Claim Additional Development Requests
  - Medical Review Targeted Probe and Educate Additional Development Requests
  - Other Audit Contractor Additional Development Requests
  - Overpayments Due to Contractor Audit Reviews
- Resources > EDI Solutions > Benefits of Electronic Attachments
- Resources > EDI Solutions > Benefits of the 277 RFI

Reducing Claim Rejections for Clinical Laboratory Improvement Amendment

Clinical Laboratory Improvement Amendments

- Quality standard for laboratory testing to ensure accuracy, reliability and timeliness of patient test results
- Different types of waivers are available
  - Effective for two years
- Some CLIA waived tests required modifier QW
  - Item 24D right of CPT/HCPCS code
- Enter ten-digit CLIA number for laboratory services billed by an entity performing CLIA-covered procedures
  - Item 23 or electronic equivalent

Steps to Successfully Check CLIA Information

- Clinical Laboratory Fee Schedule
- Clinical Laboratory Improvement Amendments (CLIA)
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 16

Reducing Claim Rejections for CPT and HCPCS

Have Current Code Books

- CPT
  - Numeric coding system that describes the services and procedures provided by a physician
- HCPCS
  - Alpha numeric coding system used by a physician to report services
- ICD-10-CM code books
  - Used to select appropriate diagnosis codes

Not Payable Under NGS Jurisdiction

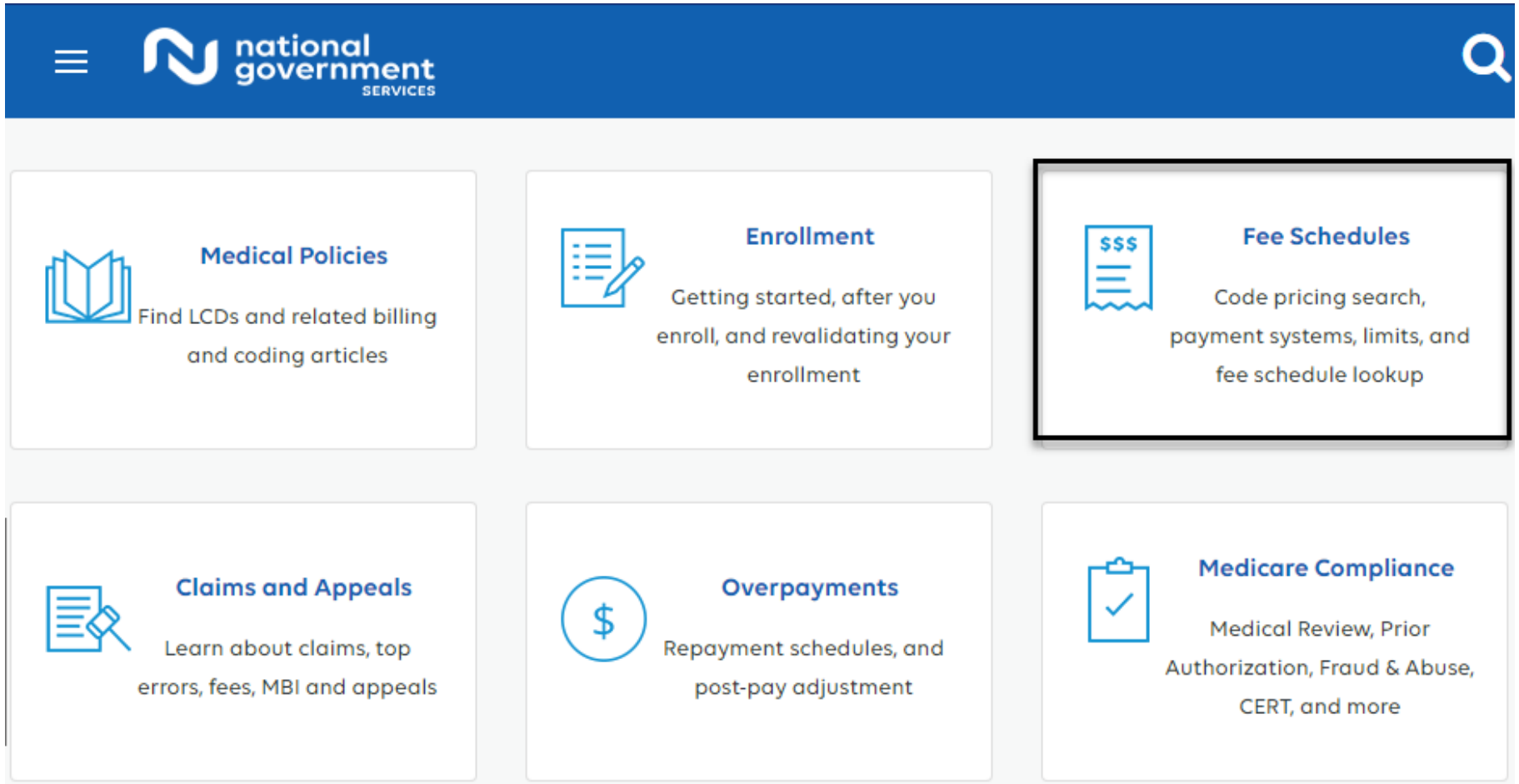
Not Payable Under NGS Jurisdiction

- Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)
  - HCPCS code and modifier combinations
    - ✓ Example HCPCS A, B, E, J, K, L, Q and V
  - Part B services processed by DME Regional Contractors
  - Item 24D on CMS -1500 or the electronic equivalent
- Do not send these claims to NGS Medicare

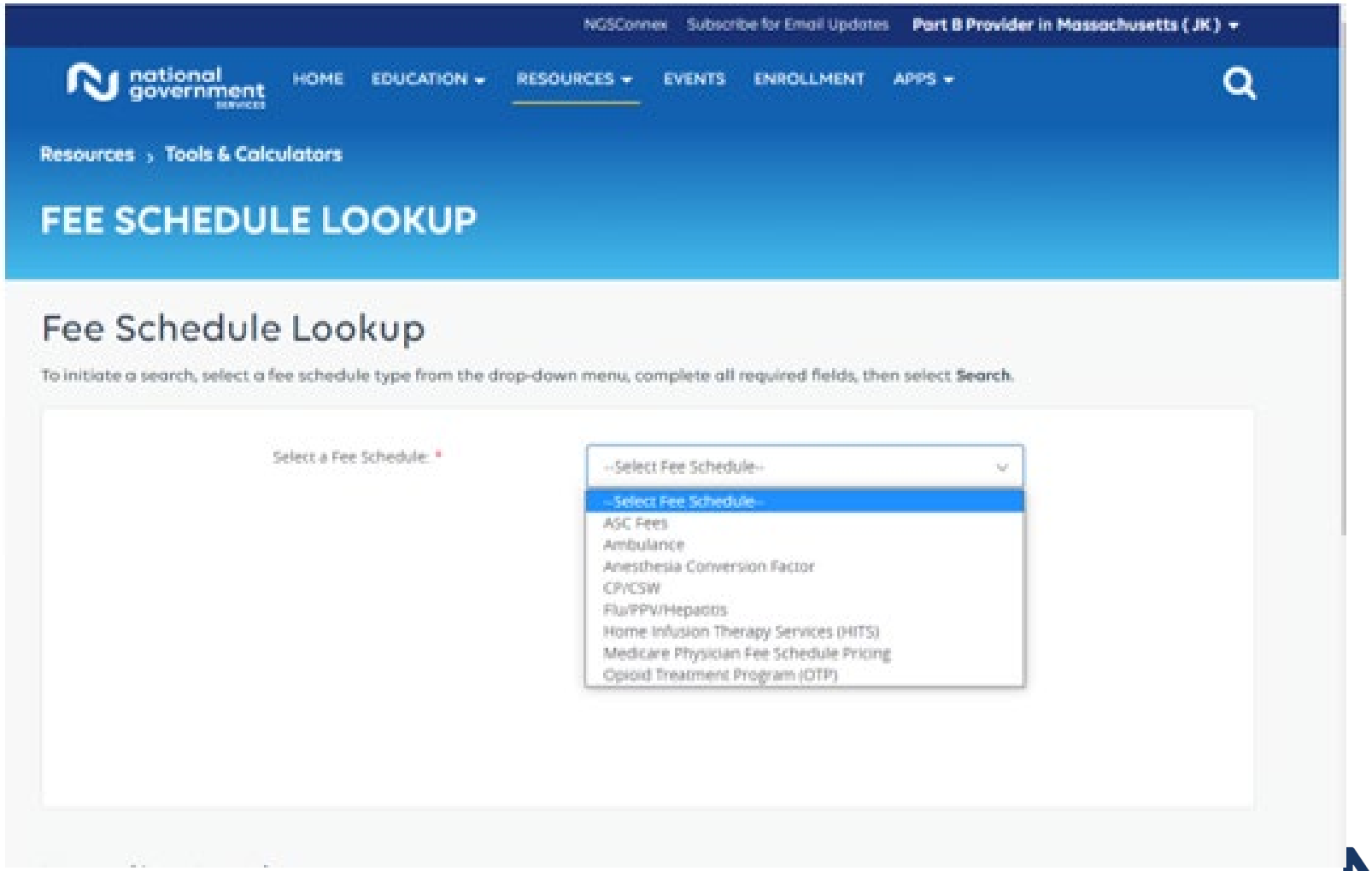
Steps to Successfully Check Jurisdictions

- Know what codes are billable to DMEMAC
- DME MAC Jurisdiction A
    - CT-MA-ME-NH-NY-RI-VT
- DME MAC Jurisdiction B
    - IL-MN-WI
- Jurisdiction Code List
    - All Jurisdictions

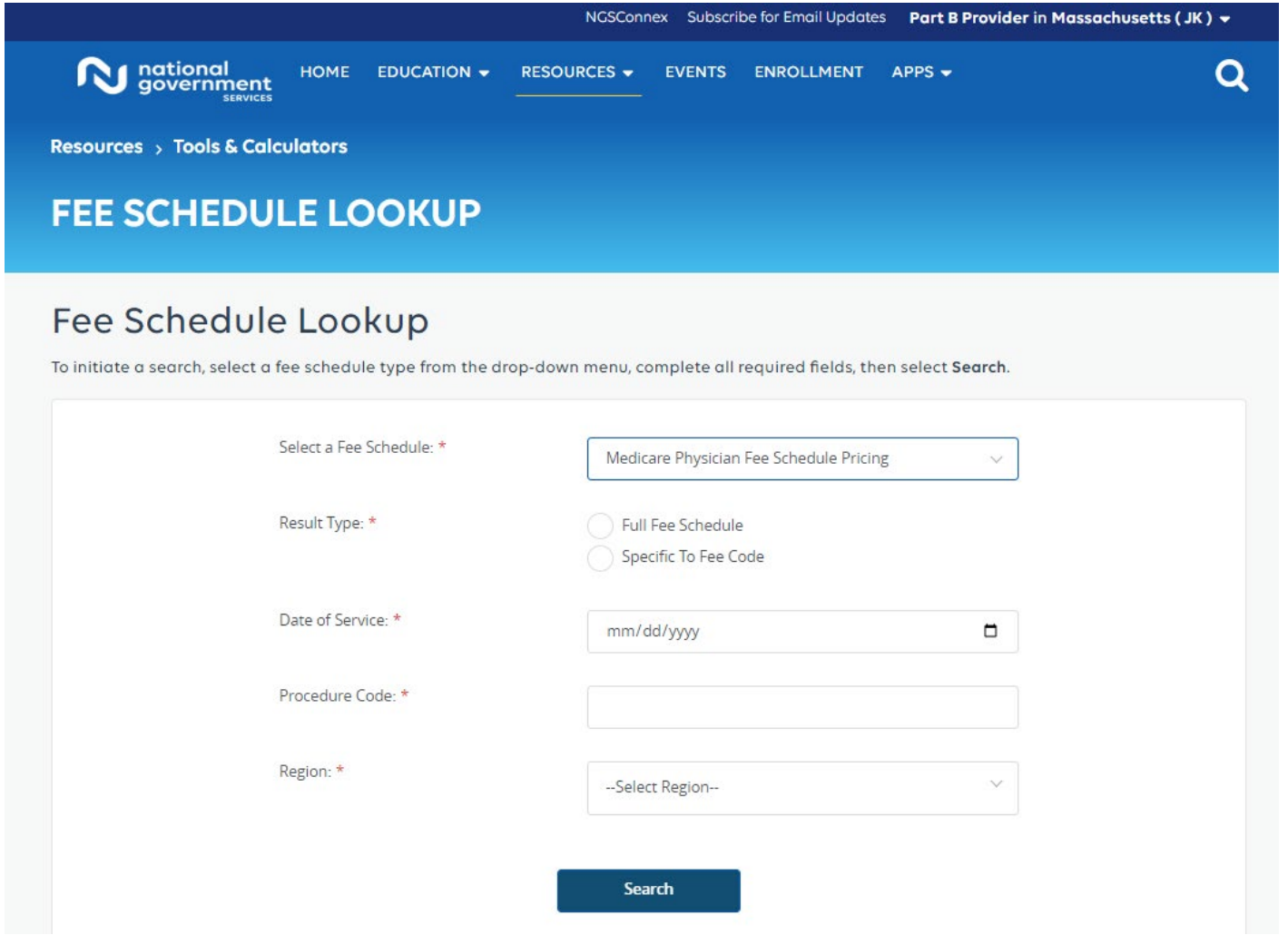
Medicare Physician Fee Schedule



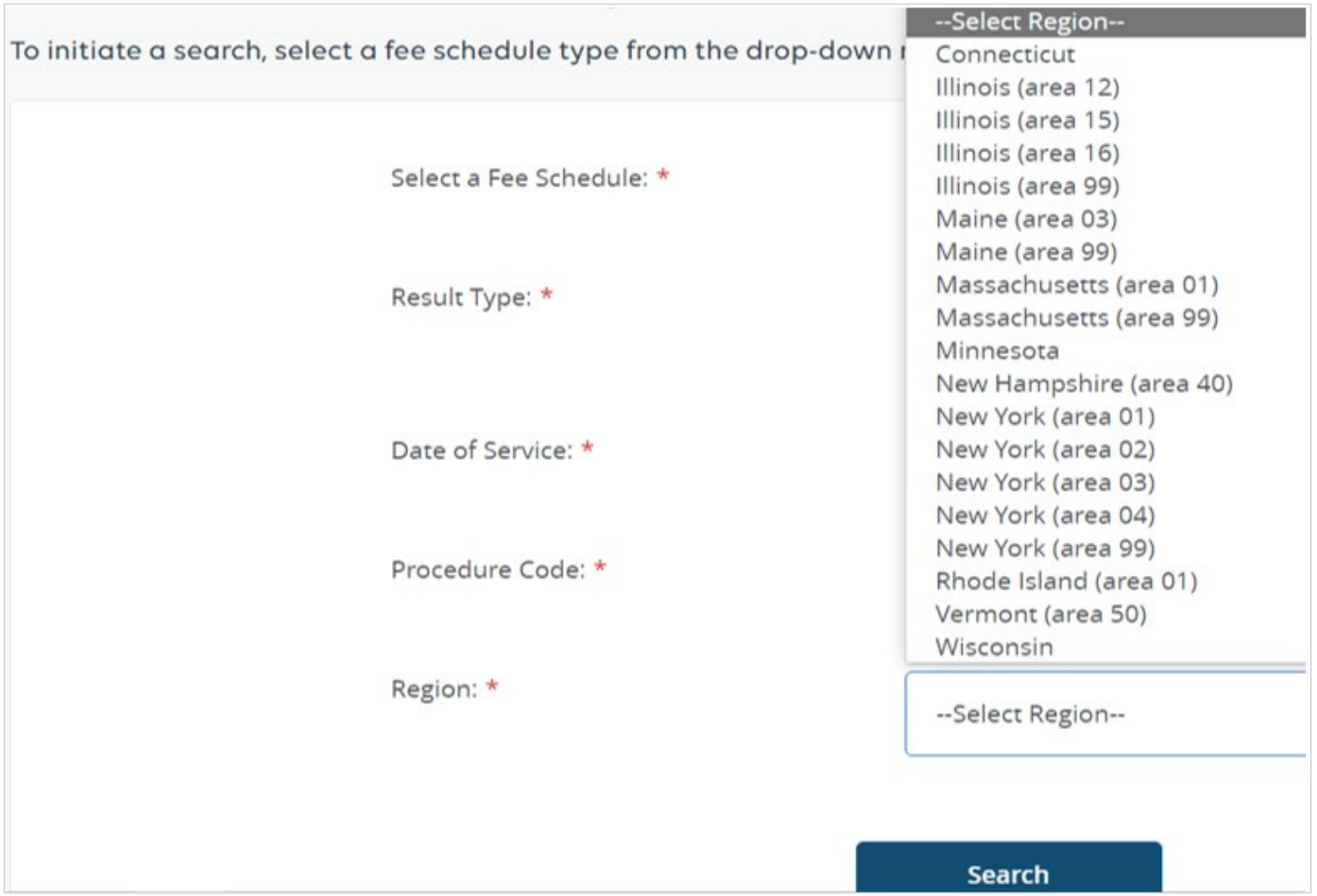
Fee Schedule Lookup – Types



Fee Schedule Lookup



Fee Schedule Lookup – Regions



Illinois Locality/Area and County Information

Locality/Area	Counties
12	Bond, Calhoun, Clinton, Jersey, Macoupin, Madison, Monroe, Montgomery, Randolph, St. Clair, Washington
15	DuPage, Kane, Lake, Will
16	Cook
99	All Other Counties

Maine and Massachusetts, Locality/Area and County Information

Locality/Area	State	Counties
01	MA	Middlesex, Norfolk and Suffolk
99	MA	All Other Counties
03	ME	York and Cumberland
99	ME	All Other Counties

New York Locality/Area and County Information

Locality/Area	Counties
01	Manhattan
02	Bronx, Brooklyn, Nassau, Rockland, Staten Island, Suffolk, Westchester
03	Columbia, Delaware, Dutchess, Greene, Orange, Putnam, Sullivan, Ulster
04	Queens
99	Albany, Oneida, Allegany, Onondaga, Broome, Ontario, Cattaraugus, Orleans, Cayuga, Oswego, Chautauqua, Otsego, Chemung, Rensselaer, Chenango, Saratoga, Clinton, Schenectady, Cortland, Schoharie, Erie, Schuyler, Essex, Seneca, Franklin, Steuben, Fulton, St. Lawrence, Genesee, Tioga, Hamilton, Tompkins, Herkimer, Warren, Jefferson, Washington, Lewis, Wayne, Livingston, Wyoming, Madison, Yates, Monroe Montgomery, Niagara

Policy Indicators

- Procedure status indicators
- Global surgery
- Facility pricing
- Preoperative
- Interoperative
- Postoperative
- Multiple surgery
- Bilateral surgery
- Assistant at surgery
- Two surgeons
- Team surgery

Procedure Status Indicators

- Field indicates whether the code is in the fee schedule and whether it is separately payable if the service is covered
- Presence of an active (or valid) status code does not mean the service is covered by Medicare
- Service may be valid according to the list but may not be considered covered due to other criteria such as medical necessity or global surgery rules

Procedure Status Policy Indicators

Policy Indicator	Description
A	Active code
B	Bundled code
C	Carriers price the code
E	Excluded from Physician Fee Schedule by regulation
I	Not valid for Medicare purposes
N	Noncovered Services: These services are not covered by Medicare
R	Restricted Coverage: Special coverage instructions apply

PC/TC Indicator

- Indicator describes physician services that have global concept, professional or technical components
- These include diagnostic and therapeutic radiology services, certain diagnostic tests that involve a physician's interpretation and physician pathology services
- Indicators identify TC for technical component and 26 professional component (PC)

PC/TC Policy Indicators

Policy Indicator	Description
0	The concept of PC/TC does not apply since physician services cannot be split into professional and technical components
1	These codes have both a professional and technical component. Modifiers 26 and TC can be used with these codes
2	Professional Component Only Codes
3	Technical Component Only Codes
4	Global Test Only Codes

Global Surgery

- Indicator provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service
- Global surgery, includes all the necessary services normally furnished by a surgeon before, during and after a procedure
- Medicare payment for surgical procedure includes the preoperative, intra-operative, and postoperative services routinely performed by the surgeon or by members of the same group with the same specialty
- Physicians in same group practice who are in the same specialty must bill and be paid as though they were a single physician

Global Surgery Policy Indicators

Policy Indicator	Description
000	Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable
010	Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a ten-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable
090	Major surgery with a one-day preoperative period and 90-day postoperative period included in the fee schedule payment amount

Multiple Procedure (Modifier 51)

- Indicator for which payment adjustment rule for multiple surgical procedures applies
- Multiple surgeries are separate procedures performed by single physician or physicians in same group practice on same patient at same operative session or on same day for which separate payment may be allowed and reduced
- Providers do not use modifier 51

Multiple Procedure Policy Indicators

Policy Indicator	Description
0	No payment adjustment rules for multiple procedures apply
1	Standard payment adjustment rules in effect before 1/1/1996, for multiple procedures apply. **100 percent, 50 percent, 25 percent, 25 percent, 25 percent**
2	Standard payment adjustment rules for multiple procedures apply. **100 percent, 50 percent, 50 percent, 50 percent, 50 percent**
3	Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (that is, another endoscopy that has the same base procedure)

Bilateral Surgery (Modifier 50)

- Indicates services subject to a payment adjustment
- Bilateral services are procedures that can be performed on both sides of the body during same session or on same day by same physician or other qualified health care professional

Bilateral Surgery Policy Indicators

Policy Indicator	Description
0	150 percent payment adjustment for bilateral procedures does not apply
1	150 percent payment adjustment for bilateral procedure applies
2	150 percent payment adjustment for bilateral does not apply
3	The usual payment adjustment for bilateral procedures does not apply

Assistant At Surgery (Modifiers 80/AS)

- Indicates services where assistant at surgery may be paid
- An assistant surgeon is defined as a physician who actively assists the operating surgeon
  - Assistant may be necessary because of the complex nature of procedure(s) or the patient's condition
  - Assistant is usually trained in same specialty
  - Assistant at surgery may be physician assistant, nurse practitioner or nurse midwife acting under the direct supervision of a physician, where physician acts as surgeon and the assistant at surgery as an assistant
- Assistant at surgery modifiers include
  - 80 if the services are by a MD or DO
  - AS if by an NP, PA or CNS

Assistant At Surgery Policy Indicators

Policy Indicator	Description
0	Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity
1	Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid
2	Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid
9	Concept does not apply

Co-surgeons (Modifier 62)

- Indicator for services that two surgeons, each in different specialty
- Co-surgeons are defined as two or more surgeons, where the skills of both surgeons are necessary to perform distinct parts of a specific operative procedure
- Co-surgery is always performed during the same operative session

Co-surgeons Policy Indicators

Policy Indicator	Description
0	Co-surgeons not permitted for this procedure
1	Co-surgeons could be paid, though supporting documentation is required to establish the medical necessity of two surgeons for the procedure
2	Co-surgeons permitted and no documentation required if the two-specialty requirement is met
9	Concept does not apply

Team Surgery (Modifier 66)

- Indicator for services for which team surgeons may be paid
- Under some circumstances, highly complex procedures may require the services of a surgical team, consisting of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and complex equipment
- Benefits are allowed for medically necessary procedures and allowance(s) will be determined on an individual consideration basis

Team Surgery Policy Indicators

Policy Indicator	Description
0	Team surgeons not permitted for this procedure
1	Team surgeons could be paid, though supporting documentation required to establish medical necessity of a team; pay by report
2	Team surgeons permitted; pay by report
9	Concept does not apply

Fee Schedule Assistance

- The fee schedule assistance page provides access to information about fee schedule definitions and acronyms

Medicare Physician Fee Schedule (MPFS) Pricing and Database (DB)

Procedure Code	Effective Date	State/Territory	Locality	Short Description
76706	01/01/2022	14112	03	Us abdl aorta screen aaa

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	110.21	104.70	120.41	110.21	104.70	120.41
26 (Details)	26.49	25.17	28.95	26.49	25.17	28.95
TC (Details)	83.72	79.53	91.46	83.72	79.53	91.46

MPFSDB 76706

Modifier Selected: (blank)

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
A	33.8872	1.0000	0.55	2.61	2.61

Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
0.05	1.000	1.005	0.654	0.00	

Global Surgery	Facility Pricing	PC/TC	Preoperative Percentage	Interoperative Percentage	Postoperative Percentage
XXX	1	1	00.00%	00.00%	00.00%

Multiple Surgery	Bilateral Surgery	Assistant At Surgery	Two Surgeons	Team Surgery
0	0	0	0	0

MPFSDB 47480

Medicare Physician Fee Schedule Pricing Fee Schedule

Procedure Code	Effective Date	State/Territory	Locality	Short Description
47480	01/01/2023	14112	03	Incision of gallbladder

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	854.96	812.21	934.04	854.96	812.21	934.04

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
A	33.8872	1.0000	13.25	9.87	9.87
Malpractice RVU	**Work GPCI**	**Practice GPCI**	**Malpractice GPCI**	**Reduced Therapy Amt**	**Endoscopic Base**
3.15	1.000	1.005	0.654	0.00	

Global Surgery	Facility Pricing	PC/TC	Preoperative Percentage	Interoperative Percentage	Postoperative Percentage
090	1	0	09.00%	81.00%	10.00%
Multiple Surgery	**Bilateral Surgery**	**Assistant At Surgery**	**Two Surgeons**	**Team Surgery**	

MPFSDB 33935

Medicare Physician Fee Schedule Pricing Fee Schedule

Procedure Code	Effective Date	State/Territory	Locality	Short Description
33935	01/01/2023	14112	03	Transplantation heart/lung

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	4642.75	4410.61	5072.20	4642.75	4410.61	5072.20

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
R	33.8872	1.0000	91.78	31.55	31.55

Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
20.67	1.000	1.005	0.654	0.00	

Global Surgery	Facility Pricing	PC/TC	Preoperative Percentage	Interoperative Percentage	Postoperative Percentage
090	1	0	09.00%	84.00%	07.00%

Multiple Surgery	Bilateral Surgery	Assistant At Surgery	Two Surgeons	Team Surgery
2	0	2	1	2

MPFSDB 99397

Medicare Physician Fee Schedule Pricing Fee Schedule

Procedure Code	Effective Date	State/Territory	Locality	Short Description
99397	01/01/2023	14112	03	Per pm reeval est pat 65+ yr

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	0.00	0.00	0.00	0.00	0.00	0.00

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
N	0.0000	0.0000	0.00	0.00	0.00

Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
0.00	1.000	1.005	0.654	0.00	

Global Surgery	Facility Pricing	PC/TC	Preoperative Percentage	Interoperative Percentage	Postoperative Percentage
XXX	9	9	00.00%	00.00%	00.00%

Multiple Surgery	Bilateral Surgery	Assistant At Surgery	Two Surgeons	Team Surgery
9	9	9	9	9

CPT/HCPCS Code Ranges

- Anesthesia: 00000–09999
- Surgery: 10000–69999
- Radiology: 70000–79999
- Pathology/laboratory: 80000–89999
- Medicine: 90000–99999
- Ambulance: A0000–A9999
- Drugs: J0000–J9999

Not Otherwise Classified or Unlisted Codes and Documentation

- An unlisted code represents an item, service, or procedure for which there is no specific CPT or Level II alphanumeric HCPCS code
- Unlisted codes should be reported only if no other specific codes adequately describe the procedure or service
- Consider finding a CPT code that best describes service/procedure using the reduced service modifier 52
- Service/procedure(s) should be adequately documented in your medical record and submitted with each claim
  - Paper or electronic media claims
- Medicare allowable amounts are not established; therefore, allowance is based on the supporting documentation

Steps to Successfully Check CPT/HCPCS

- MPFS available on our Fee Schedule Lookup page
- Fee Schedule Assistance
- MLN® Booklet: *How To Use The MPFS Look-Up Tool (ICN 901344)*
- Top Claim Errors – Unprocessable Claim Rejections and Corrections
- Medically Unlikely Edits
- Billing Not Otherwise Classified Codes

Reducing Claim Rejections for Modifiers

Modifiers

- Two types of modifiers in MCS
  - CPT- numeric
  - HCPCS- letter and numeric
- Pricing modifiers
  - First field
- Statistical/informational modifiers
  - Second field
- Always enter pricing modifiers before statistical/informational modifiers

Modifiers- List Not All Inclusive

- Pricing Modifiers
  - Anesthesia modifiers
    - ✓ AA, AD, QK, QW, QX, QY, QZ
  - Assistant at surgery modifiers
    - ✓ AS, 80, 81, 82
  - Diagnostic modifiers
    - ✓ CT, FX, TC, 26
  - Evaluation and management
    - ✓ 24, 25, 57
  - Surgery modifiers
    - ✓ 50, 62, 66, 73, 74, 78
  - Shared care
    - ✓ 54, 55

- Statistical/informational modifiers
  - Coronary artery modifiers
    - ✓ LC, LD, LM, RC, RI
  - Eye lid modifiers
    - ✓ E1, E2, E3, E4
  - Finger modifiers
    - ✓ FA, F1, F2, F3, F4, F5, F6, F7, F8 F9
  - Toe modifiers
    - ✓ TA, T1, T2, T3, T4, T5, T6, T7, T8, T9
  - Side of body modifiers
    - ✓ LT, RT

Steps to Successfully Submitting Modifiers

CMS IOM Publication 100-04, *Medicare Claims Processing Manual*

- Chapter 23 "Fee Schedule Administration and Coding Requirements"
- Chapter 26 "Completing and Processing Form CMS-1500 Data Set"

Evaluation and Management Frequently Asked Questions

Claim Reminders

- Resubmit, redetermination or reopen
- Resubmit
  - Unprocessable denials
- Redetermination
  - Medical necessity claim denials
- Reopen
  - Minor clerical errors or omissions
- Reopenings for Minor Errors and Omissions

Questions?

Thank you! A follow-up email will be sent to attendees with the Medicare University Course Code.

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