Reducing Unprocessable Claim Rejections

9/28/2021

Today's Presenters

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Objectives

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

Agenda

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

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

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

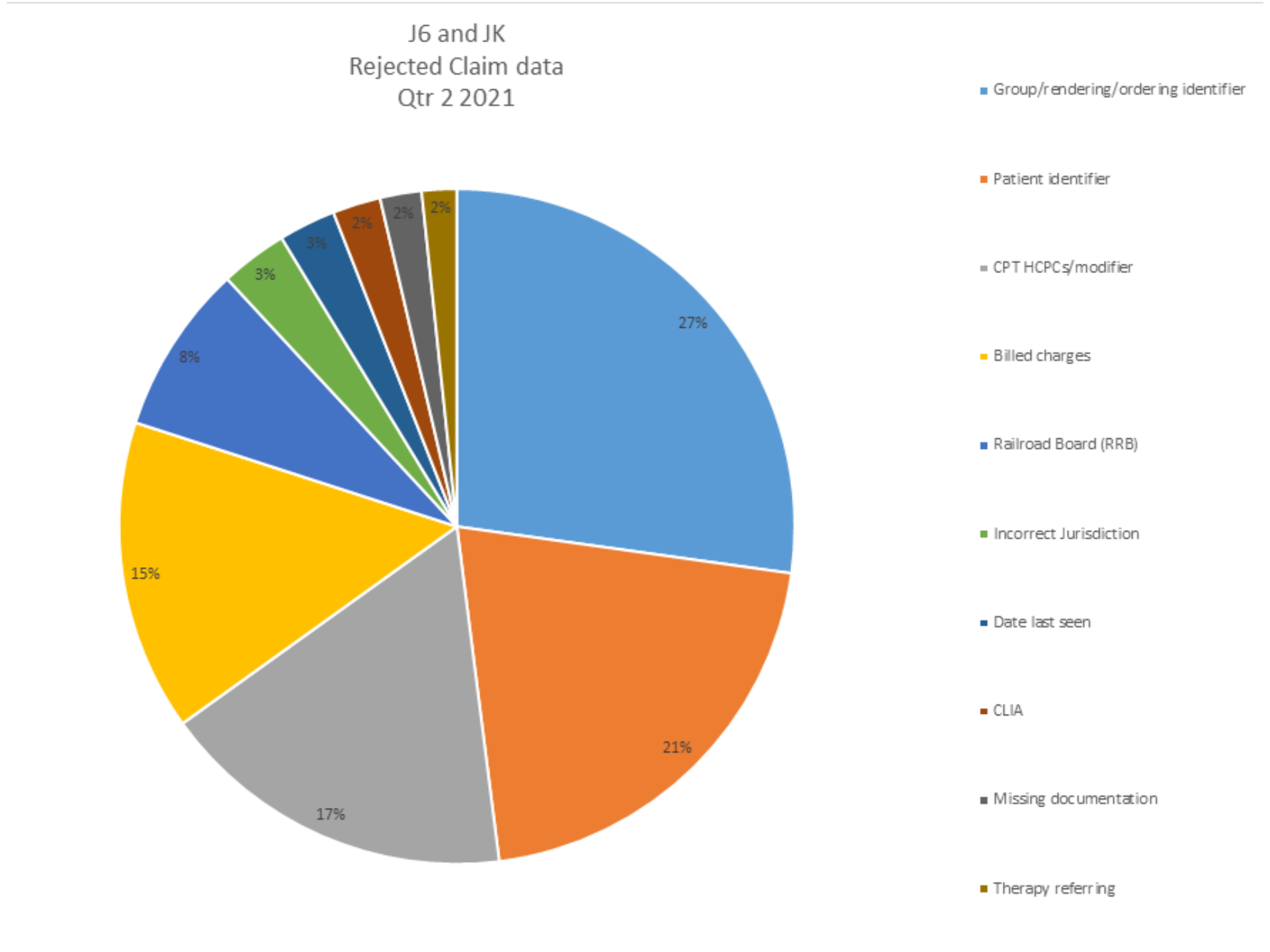
Unprocessable

- 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

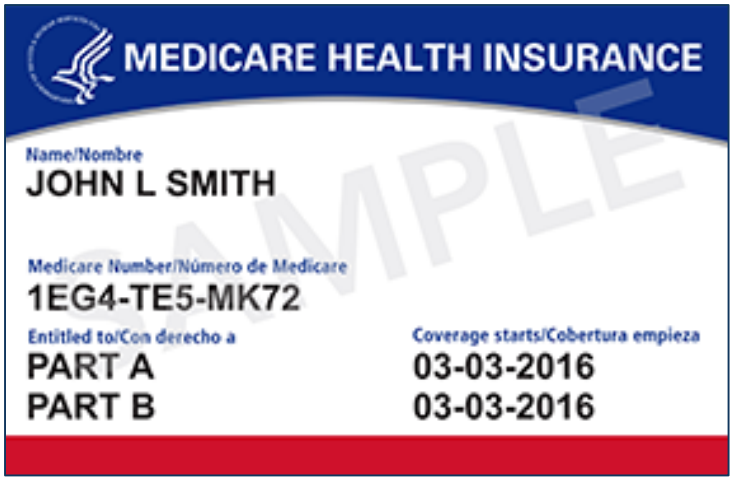
- WPC references
  - X12 Claim Adjustment Group Codes
- Remittance Advice Remarks Code reference
- Claim Adjustment Reason Code reference


J6 and JK
Rejected Claim data
Qtr 2 2021
27%
21%
17%
15%
8%
3%
3%
2%
2%
2%
Group/rendering/ordering identifier
Patient identifier
CPT HCPCs/modifier
Billed charges
Railroad Board (RRB)
Incorrect Jurisdiction
Date last seen
CLIA
Missing documentation
Therapy referring

Reducing Claim Rejections for Beneficiary Eligibility

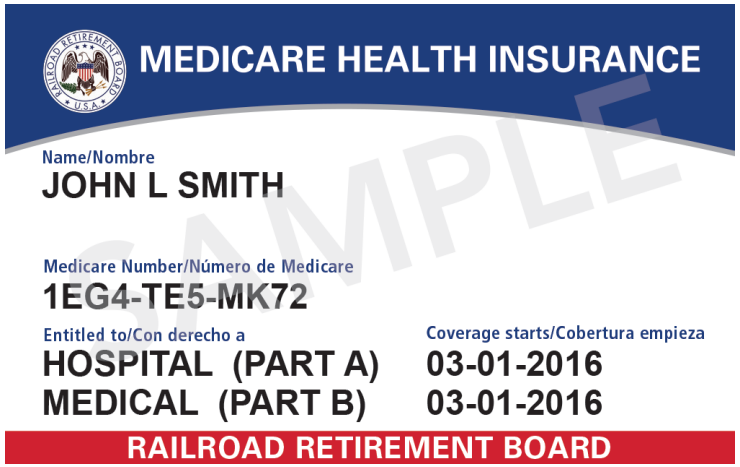
Traditional Beneficiary Eligibility

- 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



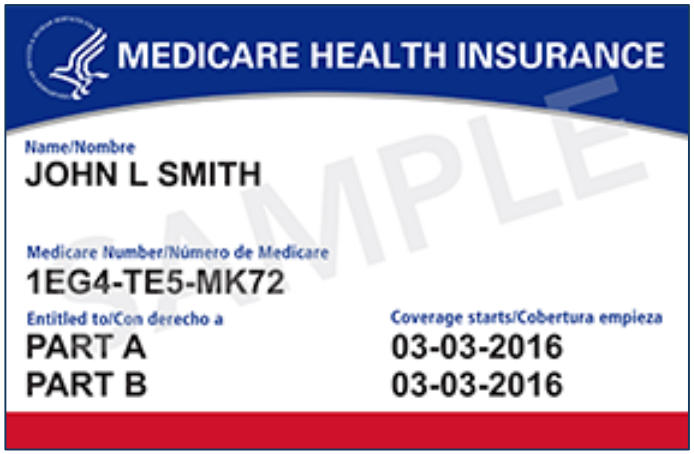
Railroad Retirement Board Eligibility

- 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



MSP

- When Medicare is Secondary
  - Enter insured's policy or group number (Item 11) and proceed to Items 11a through 11c, also complete Items 4, 6 and 7
- Electronic Data Interchange
  - Medicare Secondary Payer ANSI Specifications for 837P
    - Indication of MSP, insurance type, COB payer paid amount – claim level, COB allowed amount – claim level, contractual obligations (OTAF) – claim level, claim adjudication date – claim level, line adjudication information, line adjustments, line adjudication date

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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 a Health Insurance Claim Number (HICN) or 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 HICN/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 (HICN/MBI), etc. to touch tone for easy input into the IVR system.

Alpha-Only Touch Tone Entries

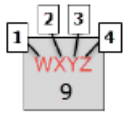
When speaking the beneficiary's name the IVR requires First Name, Last Name. However, when using touch-tone, the IVR requires Last Name, First Initial. For names, you only have to press the button on a telephone keypad that corresponds with the letter. Below are some examples:

Beneficiary Name	Converted Name	Touch Tone
John Doe	DOEJ	3 6 3 5
John St. Doe	STDOEJ	7 8 3 6 3 5
John Doe Jr.	DOEJRJ	3 6 3 5 7 5
John L. Doe Smith	DOESMITHJ	3 6 3 7 6 4 8 4 5

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

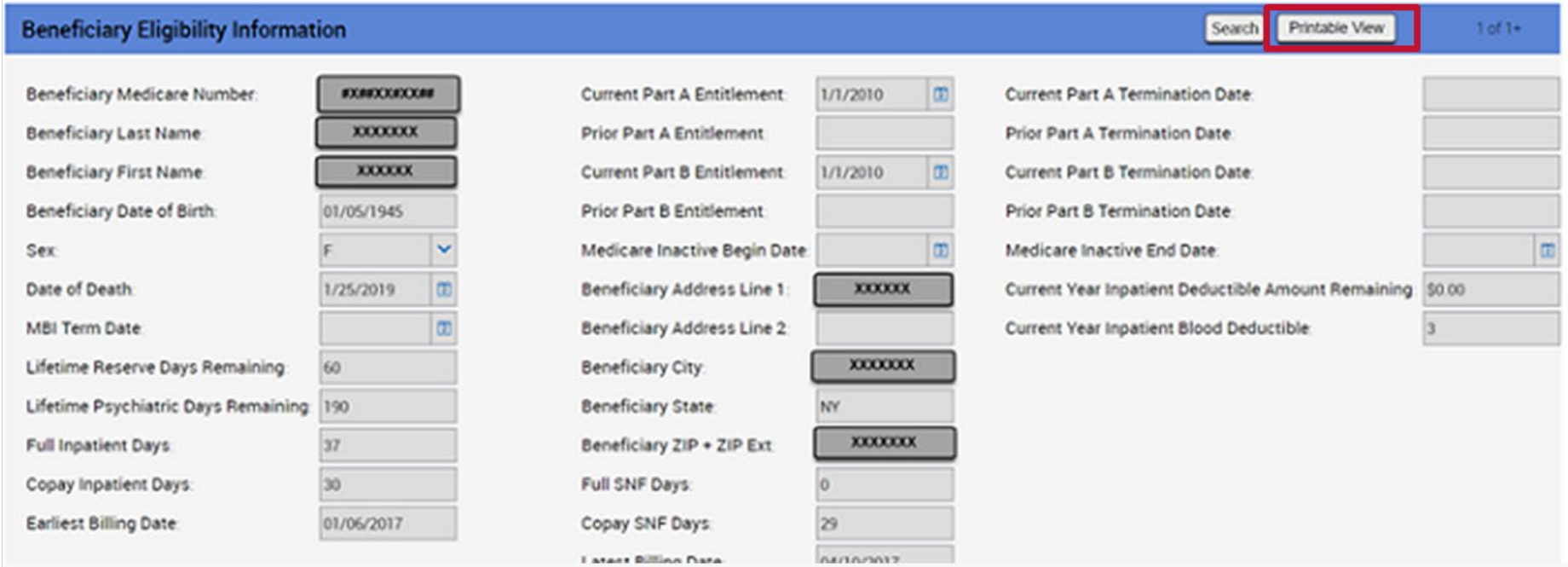
Medicare IVR Eligibility Check List

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

HICN/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: _____

296_04032018

NGSConnex Eligibility Data



Note: If a Social Security based HICN is entered to initiate the eligibility search an error message will display.

Reminder: Electronic 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
- Visit our Interactive Voice Response System section
- NGSConnex

State	IVR Number
Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont	877-869-6504
Illinois, Minnesota, Wisconsin	877-908-9499

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

Ordering and Referring Provider Information

- 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

Rendering Provider Information

- Provider that actually rendered service
- Type I
  - Individual provider
- Line Item 33 or electronic equivalent
  - NPI of rendering provider

Billing Provider Information

- Organization or individual 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

Reducing Claim Rejections for Clinical Laboratory Improvement Amendment

Clinical Laboratory Improvement Amendments

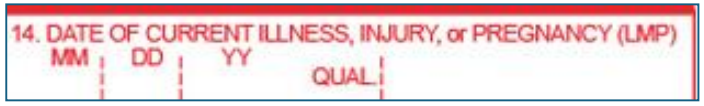
- Quality standard for laboratory testing to ensure accuracy, reliability and timeliness of patient test results
- Different types of waivers are available
  - Effective for two years
- Some CLIA waived tests required modifier QW
  - Item 24D right of CPT/HCPCS code
- Enter ten-digit CLIA number for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

Steps to Successfully Check CLIA Information

- List of Waived Tests
- Clinical Laboratory Fee Schedule
- NGS Medical Policy Education Topics
- Clinical Laboratory Improvement Amendments (CLIA)
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 16
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 23
- MLN Matters Article® *MM9956 Revised: New Waived Tests*

Initial Treatment Date

- Certain services need the initial date of treatment
  - Six-digit or eight-digit date of current illness, injury, pregnancy or chiropractic services
- Qualifier space is not used



Item No.	Claim Description	Loop	Field	Status	Data Element Description	Requirements
14	Date if current illness, injury, pregnancy	2300	DTP03 (439)	S	Accident Date	Required if Related Cause code (CLM11-1, -2 or -3) = Auto Accident (AA) or Other (OA). Enter the date of current illness or injury.
		2300	DTP03 (431)	S	Onset of current illness or injury date	Required for the initial medical service or visit performed in response to a medical emergency when the date is available and is different than the date of service
		2300	DTP03 (454)	S	Initial treatment date	Required on all claims involving spinal manipulation.
		2400**	DTP03 (454)	S	Initial Treatment Date	Required when the Initial Treatment Date is known to impact adjudication for claims involving spinal manipulation, physical therapy, occupational therapy, or speech language pathology and when different from what is reported at the claim level

Provider Place of Service Information

- Provide place where services are rendered
- Complete name, address, ZIP Code where services were furnished
  - Hospital
  - Clinic
  - Laboratory
  - Patient's home
  - Physician's office
  - Diagnostic tests subject to anti-markup
- Line Item 32 or electronic equivalent

Steps to Successfully Check Provider Data

- Data Files for Ordering and Referring
- National Plan & Provider Enumeration System
- Medicare Place of Service Codes and Descriptions
- CMS-1500 Claim Form Completion Instructions

Billed Charges

Billed Charges

- Each line submitted should have valid charge
- If there are no cents in charge amount, enter 00 or 0.01 in cents field
- 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

Requested Information Not Provided/Not Provided Timely/Insufficient

Additional Documentation Request

- NGS may need to analyze claims to determine allowance
- ADR letters will be generated
  - NGS may require 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

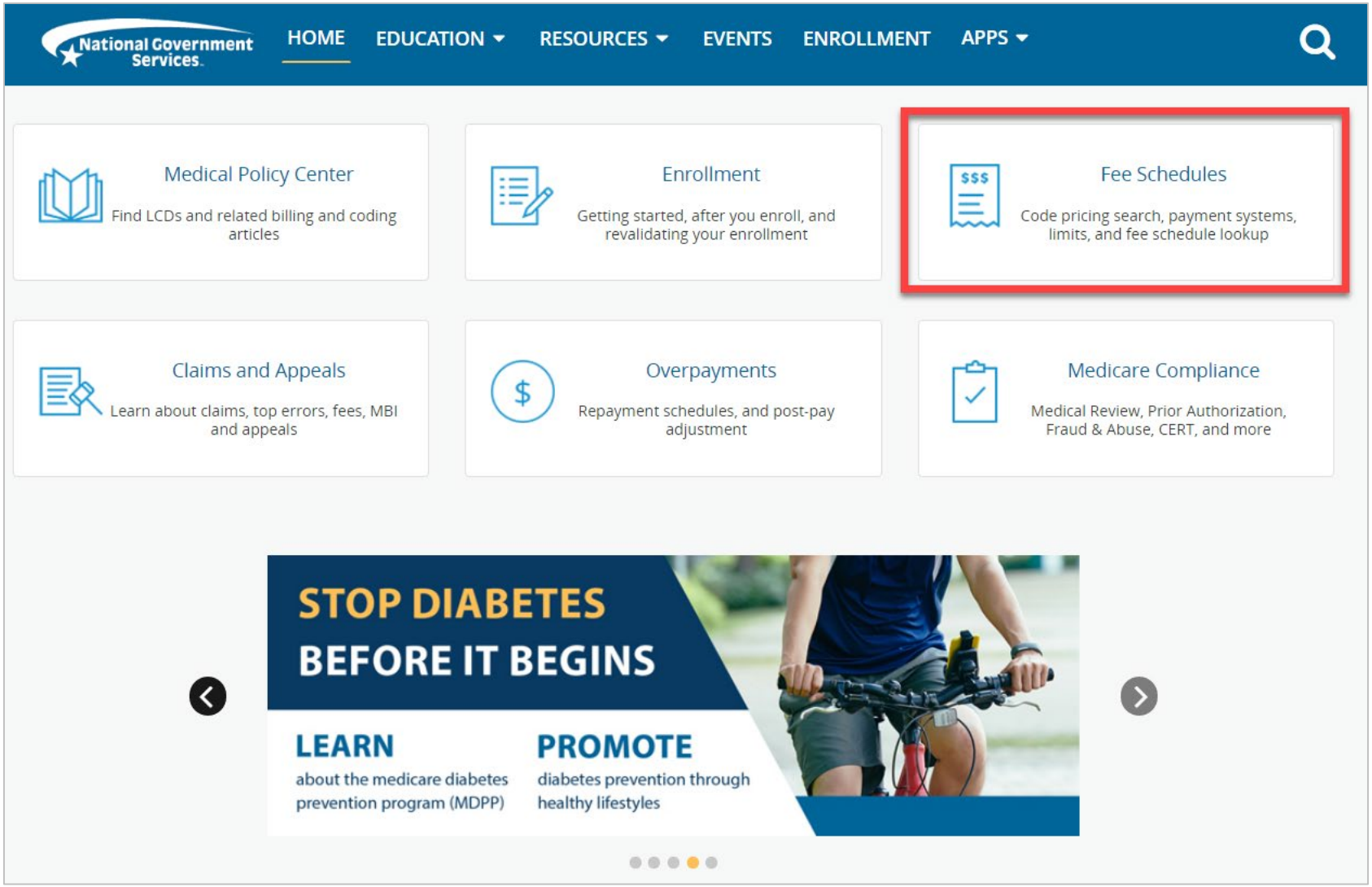
- General Information
- Additional Development/Documentation Request Timeline Calculator
- Additional Development Request Letters Guide
- Responding to an ADR
- Methods for Submitting an ADR
- ANSI 275
- ANSI 277

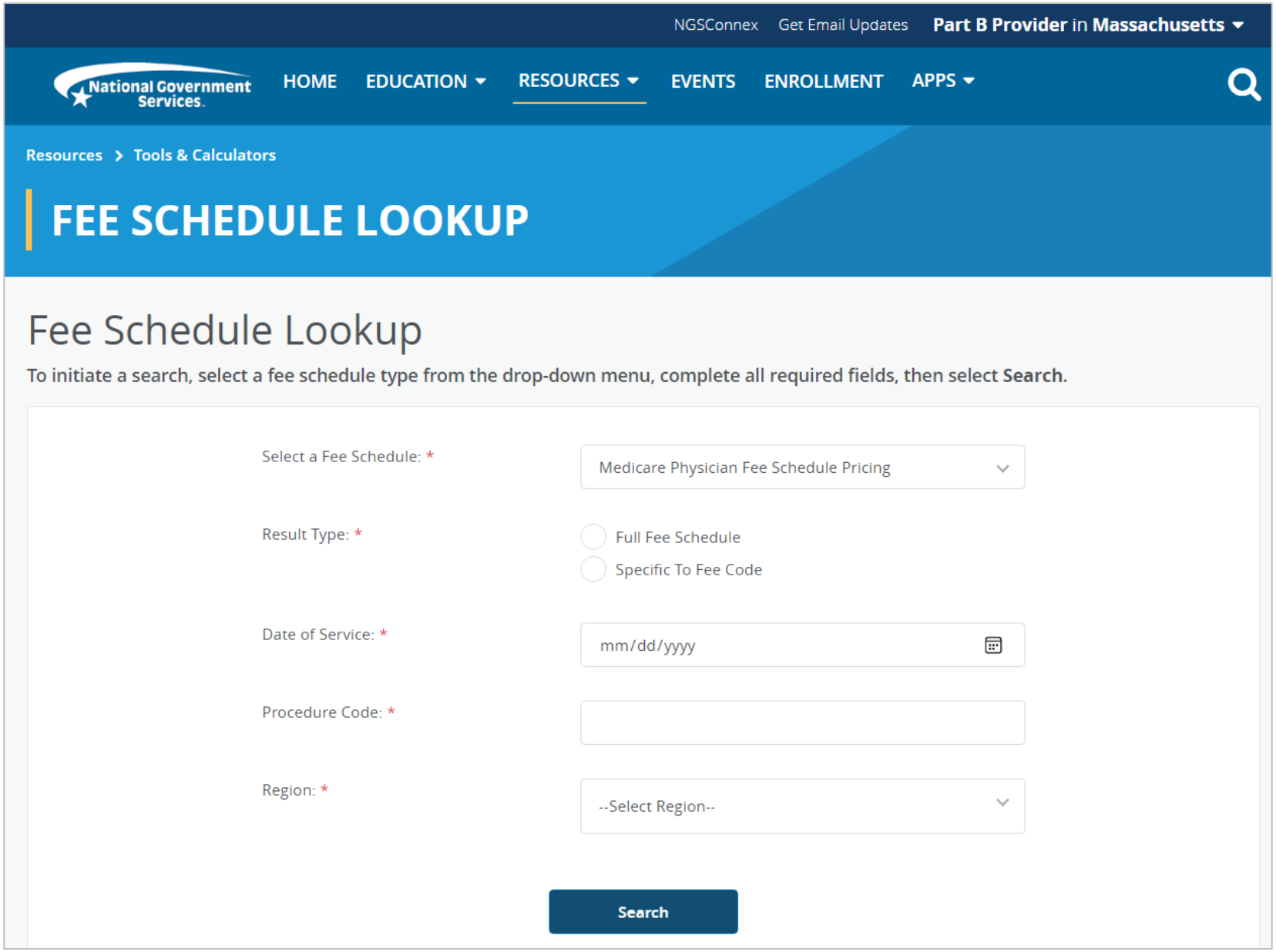
Reducing Claim Rejections for CPT and HCPCS

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

Medicare Physician Fee Schedule

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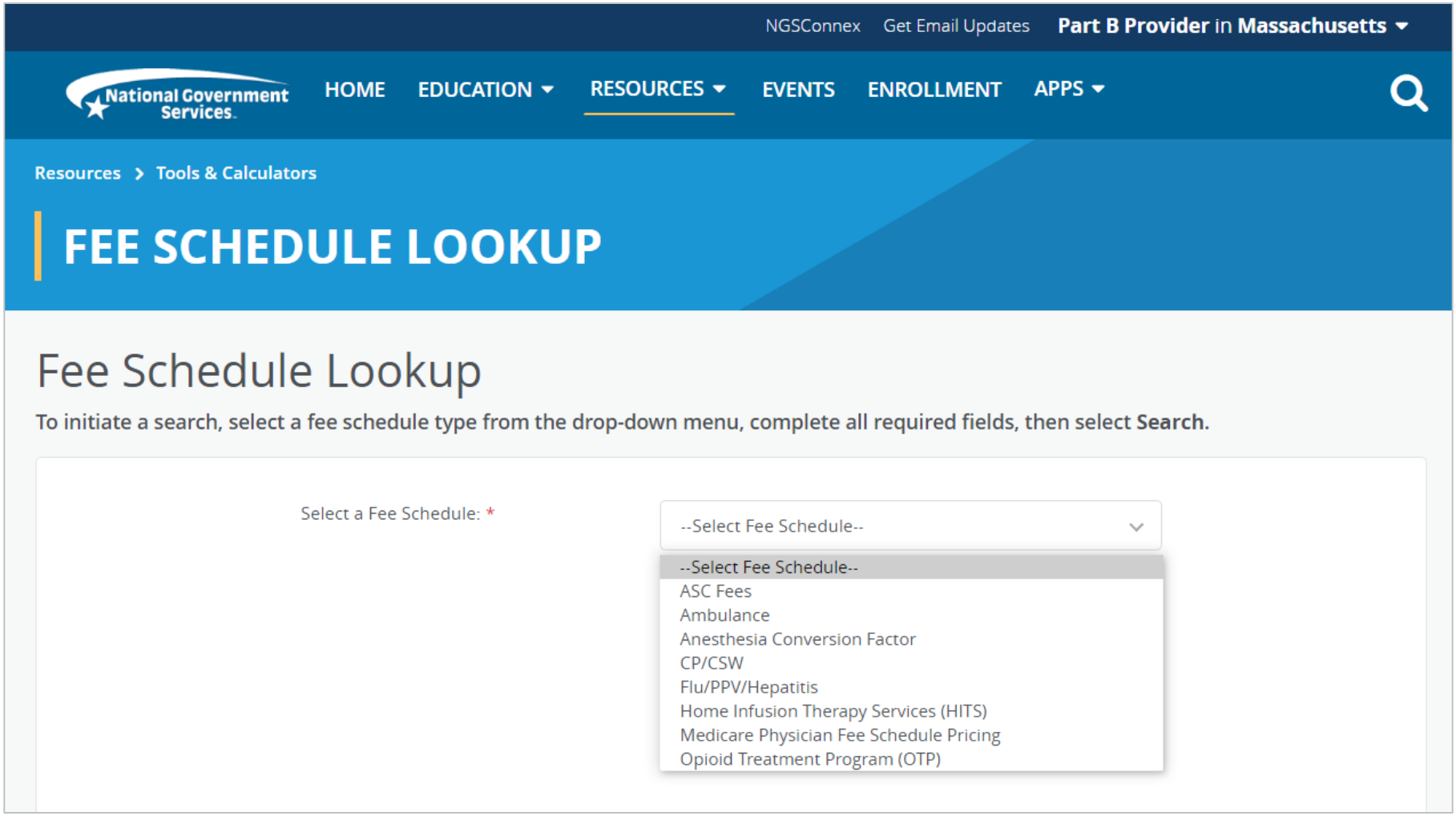
FEE SCHEDULE LOOKUP
Fee Schedule Lookup
To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select Search.
Select a Fee Schedule: *
Medicare Physician Fee Schedule Pricing
Result Type: *
Full Fee Schedule
Specific To Fee Code
Date of Service: *
mm/dd/yyyy
Procedure Code: *
Region: *
--Select Region--
Search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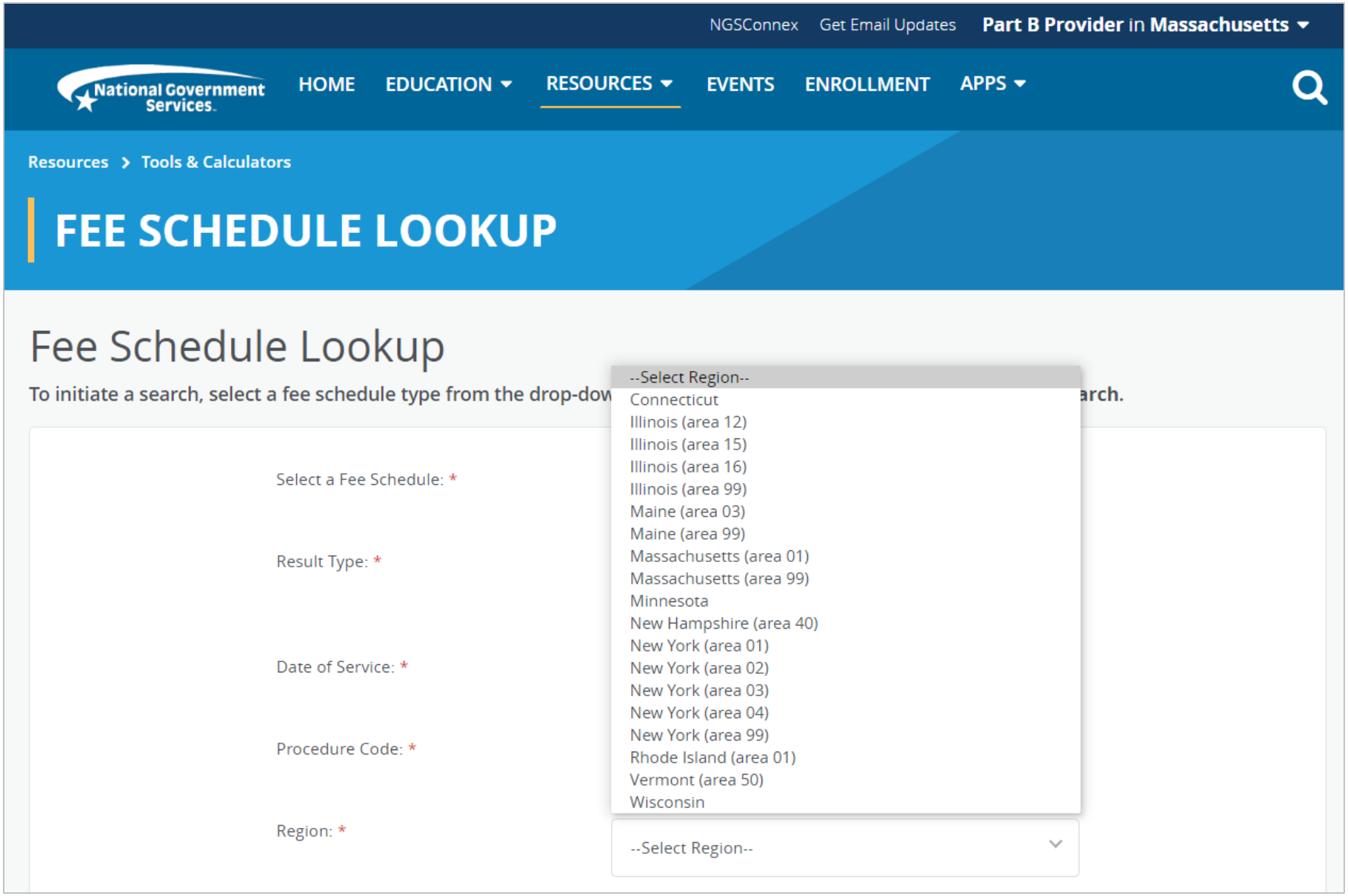
Fee Schedule Lookup
To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select Search.
Select a Fee Schedule: *
--Select Fee Schedule--
--Select Fee Schedule--
ASC Fees
Ambulance
Anesthesia Conversion Factor
CP/CSW
Flu/PPV/Hepatitis
Home Infusion Therapy Services (HITS)
Medicare Physician Fee Schedule Pricing
Opioid Treatment Program (OTP)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Fee Schedule Lookup
To initiate a search, select a fee schedule type from the drop-dow
arch.
Select a Fee Schedule: *
Result Type: *
Date of Service: *
Procedure Code: *
Region: *
--Select Region--
--Select Region--
Connecticut
Illinois (area 12)
Illinois (area 15)
Illinois (area 16)
Illinois (area 99)
Maine (area 03)
Maine (area 99)
Massachusetts (area 01)
Massachusetts (area 99)
Minnesota
New Hampshire (area 40)
New York (area 01)
New York (area 02)
New York (area 03)
New York (area 04)
New York (area 99)
Rhode Island (area 01)
Vermont (area 50)
Wisconsin

Locality Lookup

State: * New York

County: * -Select-

-Select-
Albany
Allegany
Bronx
Brooklyn
Broome
Cattaraugus
Cayuga
Chautauqua
Chemung
Chenango
Clinton
Columbia
Cortland
Delaware
Dutchess
Erie
Essex
Franklin
Fulton

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

Policy Indicator	Description
A	Active code: These codes are separately paid under the physician fee schedule if covered. There will be RVUs and payment amounts for codes with this status. The presence of an “A” indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.
B	Bundled code: Payment for covered services is always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient.)
C	Carriers price the code: Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis, following review of documentation such as an operative report.
E	Excluded from Physician Fee Schedule by regulation: These codes are for items and/or services that the CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, generally continues under reasonable charge procedures.
I	Not valid for Medicare purposes: Medicare uses another code for reporting of, and payment for, these services (code not subject to a 90-day grace period).
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)

Policy Indicator	Description
0	Physician Service Codes: Identifies codes that describe physician services. Examples include visits, consultations and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The total RVUs include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.
1	Diagnostic Tests for Radiology Services: Identifies codes that describe diagnostic tests. Examples are pulmonary function tests or therapeutic radiology procedures, e.g., radiation therapy. These codes have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier include values for physician work, practice expense and malpractice expense.
2	Professional Component Only Codes: This indicator identifies stand-alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is CPT code 93010 – Electrocardiogram; interpretation and report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.
3	Technical Component Only Codes: This indicator identifies stand-alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic test only. An example of a technical component only code is CPT code 93005 – Electrocardiogram; tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes includes values for practice expense and malpractice expense only.
4	Global Test Only Codes: This indicator identifies stand-alone codes that describe selected diagnostic tests for which there are associated codes that describe (a) the professional component of the test only, and (b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.

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 post-operative 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

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 10-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

Policy Indicator	Description
0	No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure.
1	Standard payment adjustment rules in effect before 1/1/1996, for multiple procedures apply. In the 1996 MPFSDB, this indicator only applied to codes with procedure status of 'D.' If a procedure is reported on the same day as another procedure with an indicator of 1, 2 or 3, Medicare ranks the procedures by the fee schedule amount and the appropriate reduction to this code is applied (100 percent, 50 percent, 25 percent, 25 percent, 25 percent and by report). MACs base payment on the lower of (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.
2	Standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2 or 3, MACs rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent and by report). MACs base payment on the lower of (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.
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). The base procedure for each code with this indicator is identified on the Form CMS-1500 or its electronic equivalent claim. The multiple endoscopy rules apply to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a nonendoscopic procedure). If an endoscopic procedure is reported with only its base procedure, the base procedure is not separately paid. Payment for the base procedure is included in the payment for the other endoscopy.

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

Policy Indicator	Description
0	150 percent payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier 50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100. Payment should be based on the fee schedule amount of $125 since it is lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.
1	150 percent payment adjustment for bilateral procedure applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the payment for these codes when reported as bilateral procedures on the lower of (a) the total actual charge for both sides, or (b) 150 percent of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules.
2	150 percent payment adjustment for bilateral does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier 50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base payment for both sides on the lower of (a) the total actual charges by the physician for both sides, or (b) 100 percent of the fee schedule for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on the bilateral procedure because (a) the code descriptor specifically states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure.
3	The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier 50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side or (b) 100 percent of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any applicable multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral surgeries.

Assistant at Surgery

- 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

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

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.

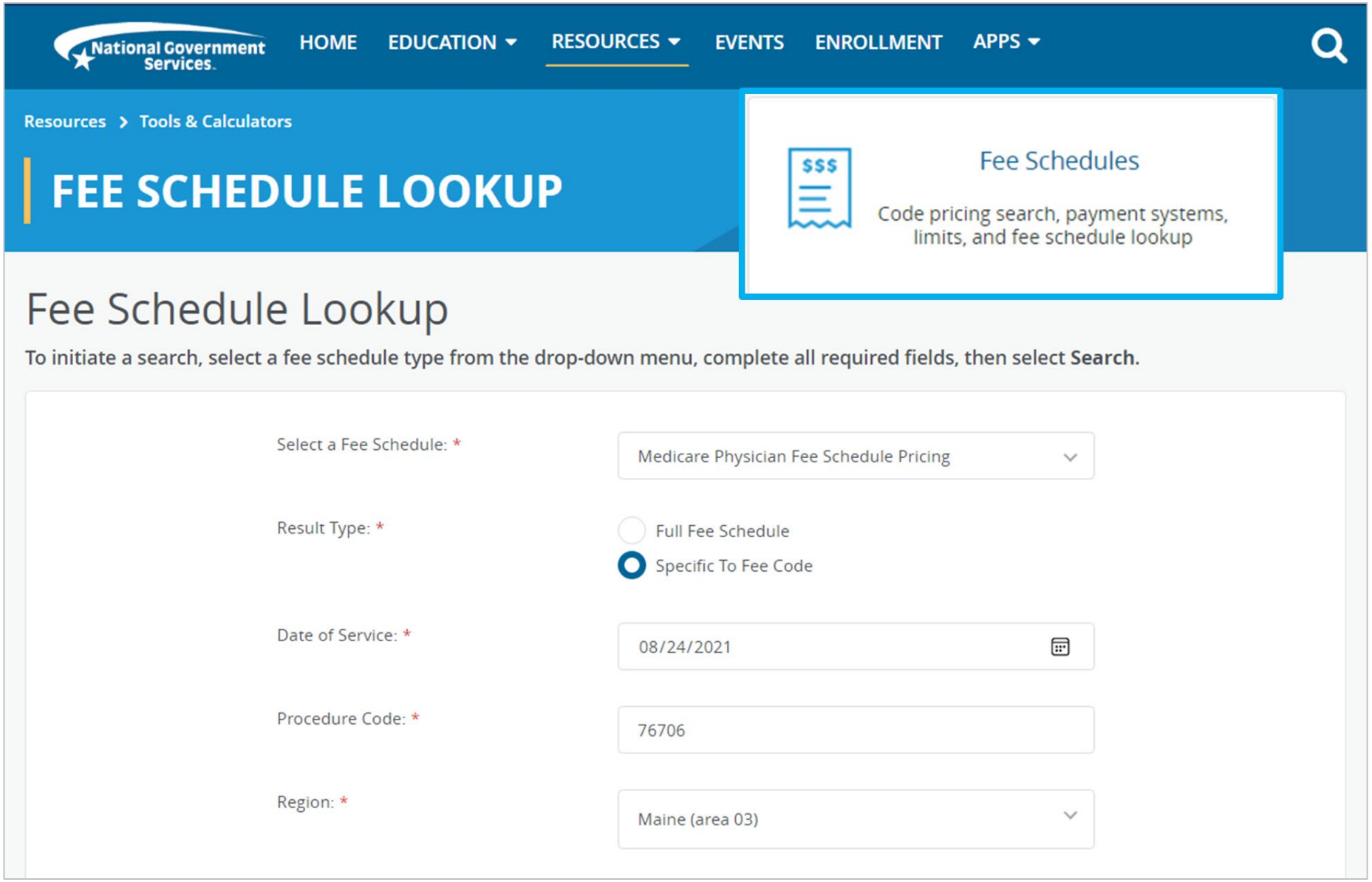
Team Surgery (Modifier 66)

- 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

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


National Government Services
HOME
EDUCATION
RESOURCES
EVENTS
ENROLLMENT
APPS
Resources > Tools & Calculators
FEE SCHEDULE LOOKUP
$$$
Fee Schedules
Code pricing search, payment systems, limits, and fee schedule lookup
Fee Schedule Lookup
To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select Search.
Select a Fee Schedule: *
Medicare Physician Fee Schedule Pricing
Result Type: *
Full Fee Schedule
Specific To Fee Code
Date of Service: *
08/24/2021
Procedure Code: *
76706
Region: *
Maine (area 03)

Medicare Physician Fee Schedule Pricing Fee Schedule

Procedure Code	Effective Date	State/Territory	Locality	Short Description
76706	01/01/2021	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)	111.47	105.90	121.79	111.47	105.90	121.79
26 (Details)	27.06	25.71	29.57	27.06	25.71	29.57
TC (Details)	84.42	80.20	92.23	84.42	80.20	92.23

76706

Modifier Selected: (blank)

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
A	34.8931	1.0375	0.55	2.62	2.62

Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
0.05	1.000	0.997	0.652	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

Medicare Physician Fee Schedule Pricing Fee Schedule

Procedure Code	Effective Date	State/Territory	Locality	Short Description
47480	01/01/2021	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)	872.05	828.45	952.72	872.05	828.45	952.72

47480

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)	872.05	828.45	952.72	872.05	828.45	952.72

Modifier Selected: (blank)

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
A	34.8931	1.0375	13.25	9.75	9.75

Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
3.10	1.000	0.997	0.652	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
2	0	2	1	0

33935

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)	4768.41	4529.99	5209.49	4768.41	4529.99	5209.49

Modifier Selected: (blank)

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
R	34.8931	1.0375	91.78	31.43	31.43

Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
20.77	1.000	0.997	0.652	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

99397

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

Modifier Selected: (blank)

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	0.997	0.652	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

- 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

Documentation for NOC and Unlisted Codes

- 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 Searchable Medicare Physician Fee Schedule (MPFS) (ICN 901344)*
- Unprocessable Claim Rejections and Corrections
- Medically Unlikely Edits
- Instructions for Use of Not Otherwise Classified or Unlisted Codes

Reducing Claim Rejections for Modifiers

Modifiers

- MCS allows up to four modifiers keyed per claim detail
- Two types of modifiers in MCS
  - Pricing modifiers
    - First field
  - Statistical/informational modifiers
    - Special coverage/informational
    - Second field
- Always enter pricing modifiers before statistical/informational modifiers

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

Steps to Successfully Submitting Modifiers

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 17 “Drugs and Biologicals”
  - 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

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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