national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Spring 2025 Virtual Conference

Understanding Medicare Compliance for Part B Providers

Being Compliant by Avoiding Claim Denials, Reopenings and Redeterminations

6/5/2025

NGSMU
NGS Medicare University

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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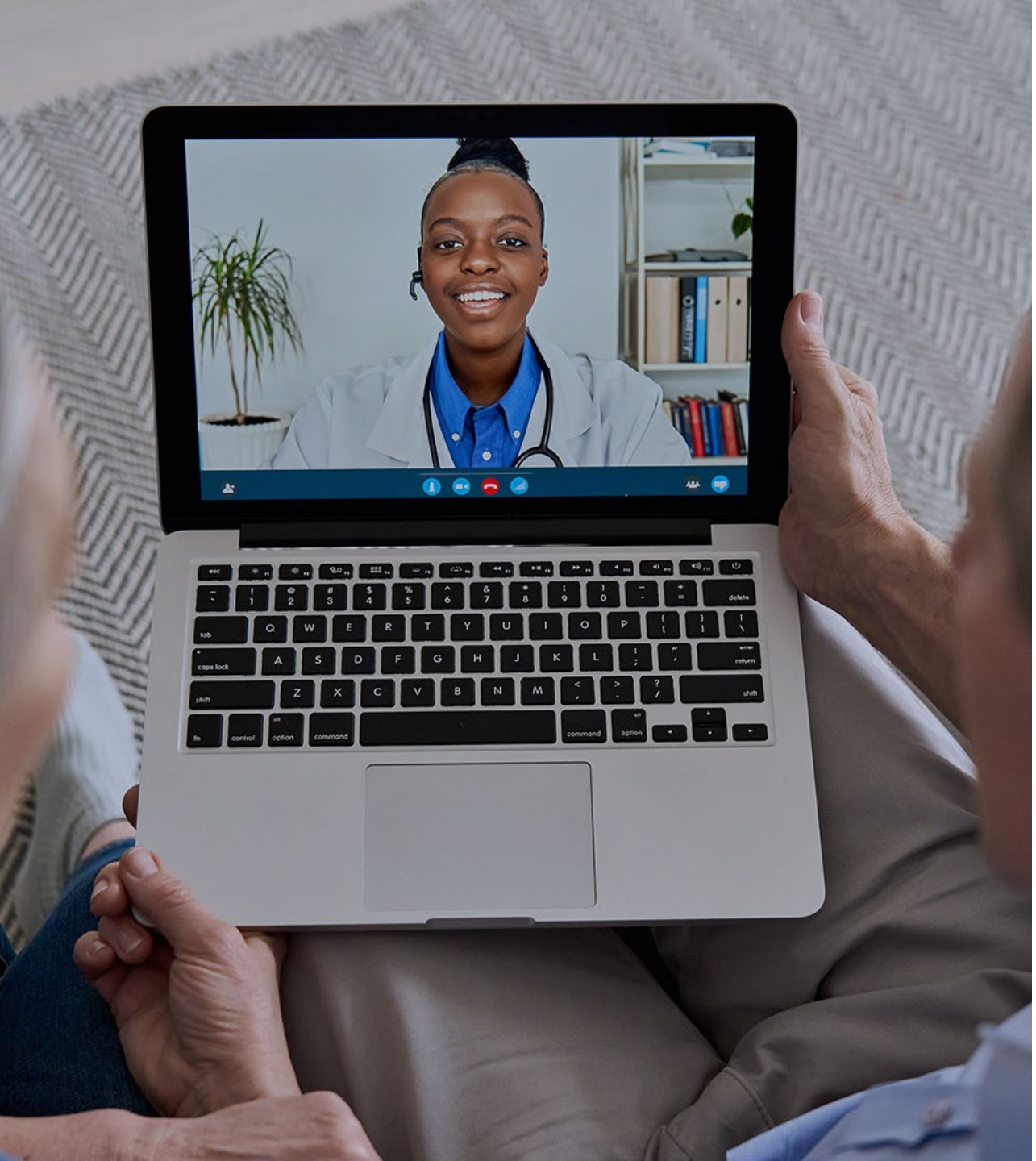

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Objective

Improving efficiency and reducing administrative burden by taking the NGS Medicare holistic approach prior to claim submissions

Agenda

- Levels of Appeal
- Step One Timeliness
- Step Two CPT/HCPCS Codes
- Step Three Modifiers
- Step Four Reopening or Appeal
- Step Five Fee Schedule
- Step Six MUE
- Step Seven NCCI PTP

Levels of Appeal

Appeals Process: Levels One–Five

- Level One
  - First Level of Appeal: Redetermination by a Medicare Contractor
  - National Government Services
- Level Two
  - Second Level of Appeal: Reconsideration by a Qualified Independent Contractor
- Three
  - Third Level of Appeal: Decision by Office of Medicare Hearings and Appeals (OMHA)
- Level Four
  - Fourth Level of Appeal: Review by the Medicare Appeals Council
- Level Five
  - Fifth Level of Appeal: Judicial Review in Federal District Court

Best Practices: Holistic Approach

- Follow these steps before submitting claim(s), an appeal or a reopening to NGS Medicare Part B
  1. Is claim within CMS time limit regulations Centers for Medicare and Medicaid Services (CMS) Internet-Only Manual (IOM) *Medicare Claims Processing Manual, Publication, 100-04,* Chapter 1 or CMS IOM *Medicare Claims Processing Manual,* Publication 100-04, Chapter 29?
  2. What is the AMA CPT Current Procedural Terminology or List of CPT/HCPCS Code(s)?
  3. Should a Modifier(s) be used with the code(s)?
  4. Do you know the difference between Reopening versus Redetermination?
  5. Have you visited the NGS website for Fee Schedule Lookup?
  6. Does the code have Medicare NCCI Medically Unlikely Edits (MUEs)?
  7. Are services distinct from other procedures Medicare National Correct Coding Initiative (NCCI) Edits?
- Once you have gone through all these steps, you may submit your claim or inquiry appropriately

Step One, Timeliness

Step One, Time Limit

- Is claim or appeal within time limit?
- Claims- one year from the date of service
  - Know claims filing exceptions to timely filing
    - Administrative error- SSA, Medicaid, Medicare Advantage
      - CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 1, Section 70.7
- Appeal- redetermination 120 days from date of initial claim determination
  - Know redeterminations exceptions to timely filing
    - Natural disasters
      - CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 29, Section 240.2
- Over time limit, do not send, instead, document your records

Scenario One Claim Time Limit

- You have identified a claim that denied 4/1/2024, and the date of service is 3/25/2024. The day you identified this was on 6/5/2025.
- What are your next steps?
    1. Do not submit the claims, instead document your records.

Scenario Two Appeals Time Limit

- You have identified a patient account where the remittance advice shows a denial for duplicate services. The remittance advice date is 2/1/2025, and the day you recognize this is 6/5/2025.
- What are your next steps?
    1. Do not submit an appeal, instead document your records.

Step One, Time Limit Wrap-up

- Know claims filing exceptions to timely filing
  - Administrative error- SSA, Medicaid, Medicare Advantage
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 70.7
- Know redeterminations exceptions to timely filing
  - Natural disasters
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 29, Section 240.2
- If you do not fall under any exceptions, document your records to save your organization time and money

Step Two, CPT/HCPCS

Step Two Policy, CPT/HCPCS Code(s)

- Know Medicare Policies and become familiar with LCDs and NCDs
- Not all covered Medicare services are subject to
  - Local Coverage Determination or
  - National Coverage Determination
- LCDs are linked to CMS Medicare Coverage Database from NGS Website Medical Policy Center
- NCDs are linked to CMS Medicare Coverage Database from NGS Website Medical Policy Center
  - National Government Services Local Coverage Determinations

Local Coverage Determinations

Local Coverage Determinations

LCD	LCD #	Billing and Coding #	Response to Comments	Related CPT/HCPCS Codes
Autonomic Function Testing *Related terms: tilt table, sudomotor*	L36236	A57024	A54403	95921, 95922, 95923, 95924, 95943
B-type Natriuretic Peptide (BNP) Testing *Related terms: congestive heart failure, acute dyspnea*	L33573	A56826		83880
Biomarker Testing (Prior to Initial Biopsy) for Prostate Cancer Diagnosis *Related terms: N/A*	L37733	A56609	A56742	81539, 84153, 84154, 86316, 81479, 0005U
Biomarker Testing for Neuroendocrine Tumors/Neoplasms *Related terms: N/A*	L37851	A57059	A56247	0007M
Botulinum Toxins *Related terms: Botox, Myobloc, Dysport,Xeomin, spasticity, chemodenervation*	L33646	A52848		43201, 43236, 46505, 52287, 64611, 64612, 64615, 64616, 64617, 64642, 64643, 64644, 64645, 64646, 64647, 64650, 64653, 67345, J0585, J0586, J0587, J0588
Breast Imaging: Breast Echography (Sonography)/Breast MRI/Ductography *Related terms: ultrasound, non-palpable masses, palpable masses*	L33585	A52849		19030, 76641, 76642, 77046, 77047, 77048, 77049, 77053, 77054, C8903, C8905, C8906, C8908

Scenario One Policy CPT/HCPCS Code(s)

- You need to submit a claim for pain management and know there is a policy National Government Services Local Coverage Determinations, and type L33622, that includes procedures
  - 20526, 20550, 20551, 20552, 20553, 20560, 20561, 20612, 27096, 28899, 64451, 64625, G0260
- What are your next steps?
  - Review the policy entirely and review ICD-10-CM codes that support and do not support medical necessity

Step Two, CPT/HCPCS Wrap-up

- Review all codes part of policy (LCD or NCD)
- Assess ICD-10-CM
- Ensure your billing staff is aware
- Monitor success
- Celebrate increased revenue

Step Three Modifiers

Modifiers

- Modifies Story
  - Who
  - What
  - When
  - Where
  - Why
  - How

Step Three, Know Modifier Usage

- Modifiers Level I CPT
  - CPT modifiers consists of two numeric digits
  - Updated annually by American Medical Association
- Modifiers level II HCPCS
  - HCPCS modifiers consists of two digits alpha alphanumeric characters
  - Updated annually by CMS

Scenario One, Step Three Modifiers

- You are submitting a claim and physician provides professional interpretation and report of complete radiological imaging of the ankle (73610) performed by hospital staff reading results using hospital-owned equipment
- How will you submit this claim?
  - 73610
  - 73610-26

Scenario two, Step Three Modifiers

- How would you submit the following codes?
  - 93010 – Electrocardiogram; interpretation and report
  - 93005 – Electrocardiogram; tracing only, without interpretation and report
    - No modifiers

Scenario Three, Step Three Modifiers

- You are submitting claim for pathology examination of tissue (88305), and three were done, two by the same rendering provider and another one by different rendering provider
- How will you submit claim?

- Line one 88305 TC, line two 88305 26 on two separate claims for each provider
- 88305 with quantity billed of three
- Line one 88305 one unit billed with rendering
  - Line two, 88305 76 repeated by same rendering
  - Line three 88305 77 to identify different rendering provider in your group

Step Three, Modifiers Wrap-up

- Review all services conducted in office, review description of CPT code(s), and if service(s) are repeated or altered in any way, claims shall contain the appropriate modifier(s)
- Results will increased provider satisfaction, based on higher rate of claim payment and need to submit fewer reopening/redeterminations
- Significant decrease in rate of appeals, correlative to lower denial rate
- Benefit to providers in fewer reopening/redetermination submissions

Step Four, Reopen or Appeal

Step Four: Reopening or Redetermination

- Know the difference between National Government Services Reopening and Redetermination
- NGS Website > Resources > Claims and Appeals > About Appeals> Reopening versus Redetermination
  - Reopening is processing to fix minor mistakes on claim(s)
  - Redetermination is examination of claim(s) that includes analysis of documentation

Submitting Reopening or Redetermination

- Reopening (Clerical Error)
- To correct a claim(s) determination resulting from minor errors, you should use the reopening process
  - Mathematical or computational mistake
  - Transposed procedure or diagnostic codes
  - Inaccurate data entry
  - Computer errors
  - Incorrect data items

- Redetermination (Appeal – First level)
- For partially paid or denied claim(s) resulting from more complex issues that require analysis of documentation
  - Coverage of furnished items and service
  - Medical necessity claim denials
  - Determination on limitation of liability provision
  - Overpayment determinations

Scenario One, Step Four

- Exact duplicate data fields submitted for claims include
  - Same beneficiary
  - Same provider
  - Same dates of service
  - Same types of services
  - Same place of service
  - Same procedure codes
  - Same billed amount
- You submitted claim and it denied for duplicate services
- What are your next steps?
  - Reopening
  - Redetermination

Scenario Two, Step Four

- You submitted with a wrong procedure code, 99215, but should have billed lower-level E/M 99213 and you recognize an overpayment
- What are your next steps?
- Reopening
- Redetermination
- Overpayment

- You have identified claims submitted with NOC codes and modifiers, 22, 52, 53, but failed to submit documentation when ADR was sent to your practice and claims rejected
- What are the next steps?
- Resubmit
- Reopening
- Redetermination

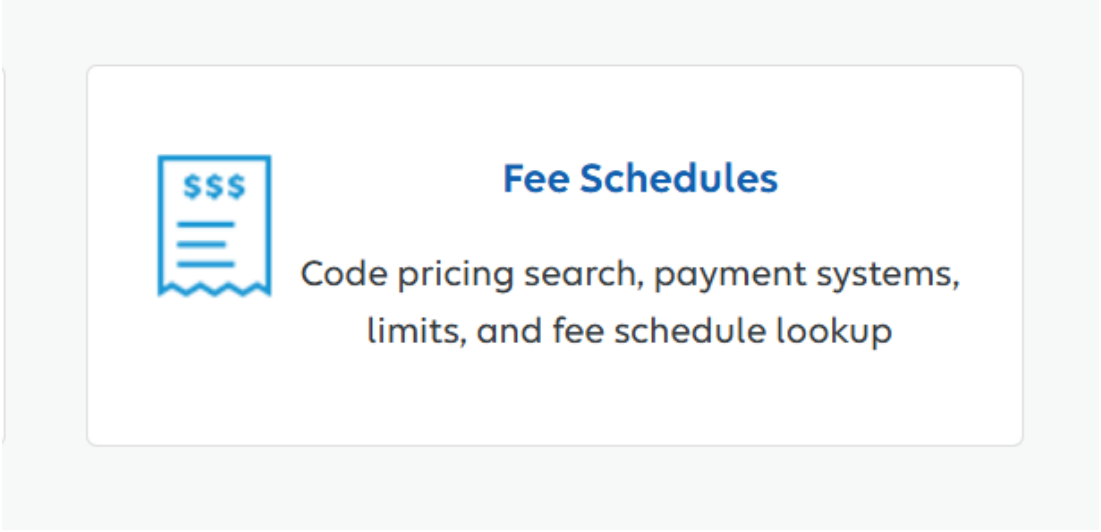
Step Four, Reopening/Appeals Wrap-up

- Know the difference between NGS Reopening and Redetermination
- Use the reference sheet located on our website
- Reduce routine reopening and redetermination submissions
- Do root cause analysis to avoid administrative burden

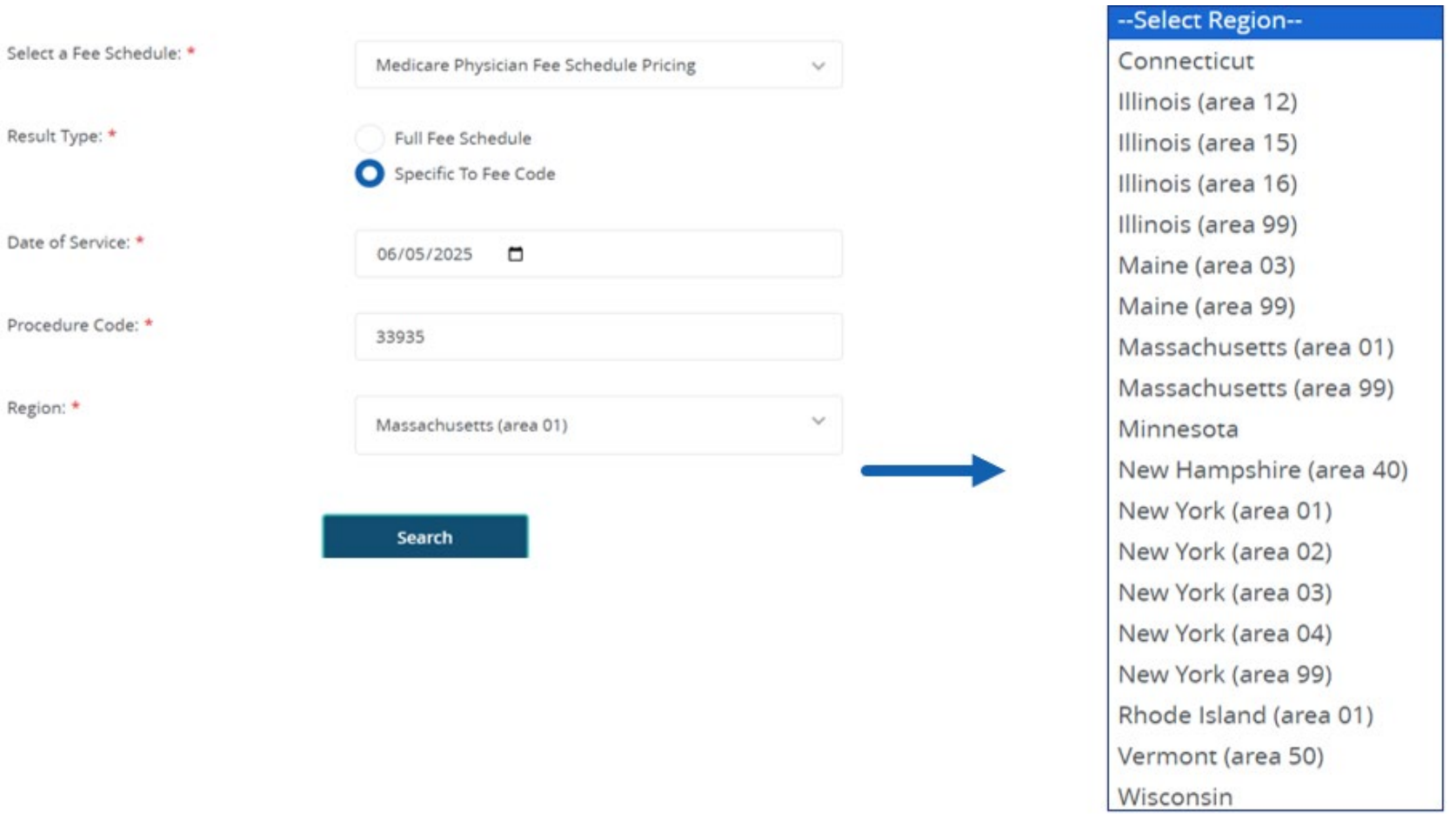
Step Five, Fee Schedule

Step Five: Fee Schedule Lookup

- Fee schedule lookup provides more than
  - 10,000 physician services
  - Relative value units
  - Fee schedule status indicator
  - Various payment policy indicators needed for payment adjustment
    - Multiple surgeries, bilateral services, assistant at surgery, cosurgery and team surgery



Fee Schedule Search



IL and NY Locality/County Information

Illinois Locality	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

New York Locality	Counties
01	Manhattan
02	Bronx, Brooklyn, Nassau, Rockland, Staten Island, Suffolk, Westchester
03	Columbia, Delaware, Dutchess, Greene, Orange, Putnam, Sullivan, Ulster
04	Queens
99	All Other Counties

MA and ME Locality/County Information

MA Localities	State	Counties
01	MA	Middlesex, Norfolk and Suffolk
99	MA	All Other Counties

ME Localities	State	Counties
03	ME	York and Cumberland
99	ME	All Other Counties

Fee Schedule Search 33935

Select a Fee Schedule: *

Medicare Physician Fee Schedule Pricing

Result Type: *

- ○ Full Fee Schedule
- ◉ Specific To Fee Code

Date of Service: *

06/05/2025

Procedure Code: *

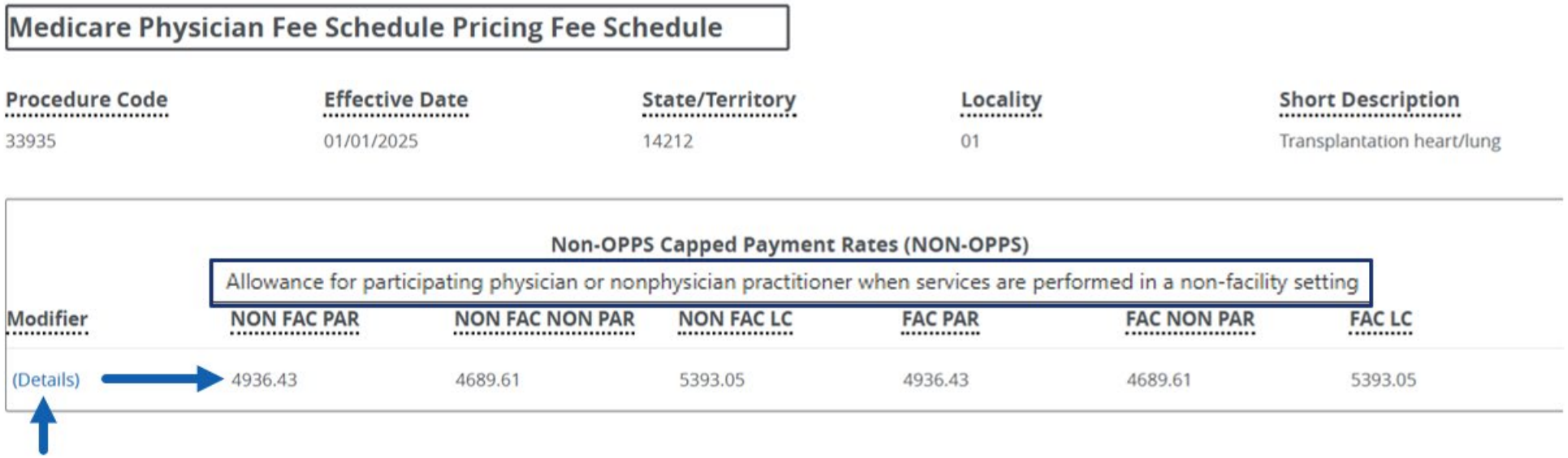
33935

Region: *

Massachusetts (area 01)

Search

Fee Schedule Results



- Click on (Details) and this takes you to database flags needed for surgical procedures and diagnostic services

Database Files

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
R	32.3465	1.0000	91.78	31.93	31.93
Malpractice RVU	**Work GPCI**	**Practice GPCI**	**Malpractice GPCI**	**Reduced Therapy Amt**	**Endoscopic Base**
20.98	1.042	1.197	0.894	0.00	

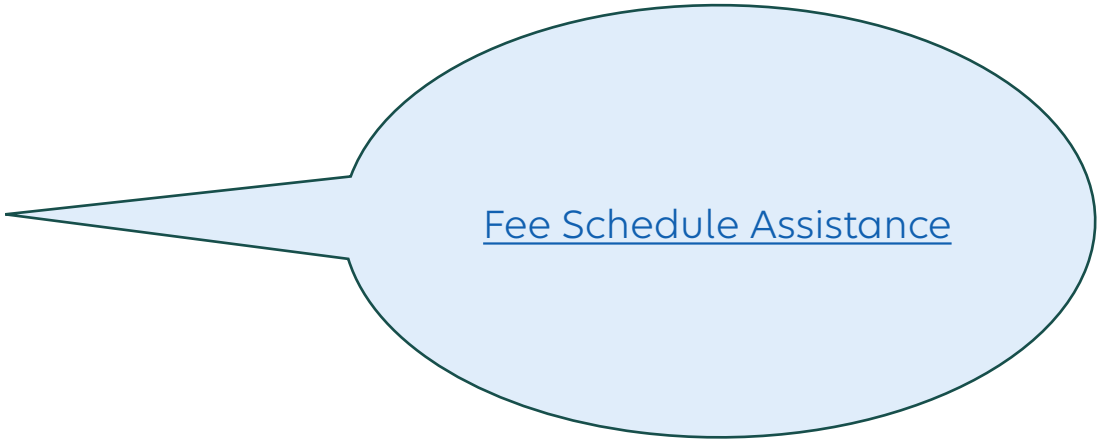
- Work RVU X Work GPCI = Work amount
- PE RVU X PE GPCI = PE amount
- MP RVU X MP GPCI = MP amount
- Total X CF (32.35) = Allowed amount
- All representing the fee schedule allowance

Policy Indicators

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

- Global surgery
- Facility site of service
- Professional/technical components
- Pre-intra-postoperative percentages
- Multiple surgery guidelines
- Bilateral surgery guidelines
- Assistant at surgery
- Two surgeons
- Team surgery



Results 33935

- Heart/lung transplant 33935
  - NGS Fee Schedule Lookup > Details
- Multiple surgery rules = 2, standard MSG (100%, 50%, 50%, 50%)
- Bilateral = 0, cannot bill bilateral
- Assistant at surgery = 2, may be permitted
- Two surgeons = 1, may be permitted with documentation
- Team surgery = 2, may be permitted with documentation
- Fee Schedule Assistance

Step Five, LCD/NCD Wrap-up

- Review fee schedule tool prior to submitting claims
- Submit documentation when submitting claim
- If not, ADRs are generated
  - If information requested was not provided or not provided timely or was insufficient, or incomplete, claim rejects
- Common error among providers is submitting claims without documentation
  - Modifiers: AS, 22, 52, 53, 62, 66, 80, NOC and unlisted codes
- Benefits of Electronic Attachments
  - 275: How To Get Started – Five Easy Steps
  - 277: How To Get Started – Five Easy Steps

Step Six, MUE

Step Six: Medically Unlikely Edits

- MUEs were developed to reduce the paid claims error rate for Part B claims
- MUE HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service
- All HCPCS/CPT codes do not have an MUE
- CMS Medicare NCCI Medically Unlikely Edits (MUEs) web page
- Practitioner Services MUE Table-R1 (ZIP) - Effective 4/1/2025; Posted 4/11/2025

MUE Adjudication Indicators

- MUE Adjudication Indicator of “1” indicates edit is claim line
- Appropriate use of NCCI modifiers (e.g., 59, 76, 77, 91, anatomic) may be used to report same code on separate lines of claim
- Medical records must support total units for date of service and use of modifiers

- MUE edits with MUE Adjudication Indicator of “2” (Date of Service Edit: Policy)
- MUE value is absolute date of service limit that may not be bypassed with modifier
- MUE edit limits with an MAI of “2” have been rigorously reviewed within CMS
- Units more than MUE value on date of service would be considered impossible because of code definition, anatomical consideration, CMS statute, regulation or sub-regulatory guidance

- MUE edits with MUE Adjudication Indicator “3” (Date of Service Edit: Clinical)
- Medically highly unlikely more units than MUE value would ever be performed on same date of service; same patient
- Quantity limits based on clinical benchmarks and criteria (e.g., nature of service, prescribing information) combined with data
- MUE limits will be applied during claim processing

Scenario One, Step Six

- MUE is maximum units of service that provider would report under most circumstances for single beneficiary on single date of service

- Example
- Excision of benign lesion 11400
  - 11400 = MUE 3 date of service edit: clinical data
- Pathology examination 88305
  - 88305 = MUE 16 date of service edit: clinical data
- Critical care 99292
  - 99292 = MUE 8 date of service edit: clinical data

Scenario Two, Step Six

- You are ready to submit claims for multiple laboratory, radiology, diagnostic and medical services and are using some procedures listed below
  - 11045, 17003, 62328, 71045, 73030, 73630, 73721, 88305, 88307, 88312, 93010, 99292, G2212
- What are your next steps?
  - Look at Medicare NCCI Medically Unlikely Edits (MUEs) and bill with appropriate quantity billed

Step Six, MUE Wrap-up

- Review all codes that need to be submitted on one claim, identify each code that requires multiple quantities or those that required modifier(s) to differentiate same services
- Avoid fragmented billing and causing duplicate claim denials
  - If repeated, some procedures may be reported with 76/77
  - If distinct, some procedures may be reported with 59 or subsets EXPU
  - Some codes may be add-on codes and should be billed appropriately

Step Seven, NCCI PTP

Step Seven, National Correct Coding Initiative

- Implementation NCCI
  - Promote national correct coding methodologies
  - Control improper coding
- Use CMS NCCI
  - Report most comprehensive code
  - Use modifiers to report special circumstances
  - Refer to CMS NCCI edit table
    - Medicare National Correct Coding Initiative (NCCI) Edits
- Separate procedure should not be reported when performed along with another procedure in anatomically-related region through same skin incision or surgical approach

Medicare NCCI PTP Edits

- Medicare NCCI Procedure to Procedure (PTP) Edits

Practitioner PTP Edits

Practitioner PTP Edits v311r0 (675,242 Records) 0001A/0591T--25680/G0471 (ZIP) - Effective April 1, 2025;
Posted March 5, 2025

Practitioner PTP Edits v311r0 (674,813 Records) 25685/01810--38760/G0471 (ZIP) - Effective April 1, 2025;
Posted March 5, 2025

Practitioner PTP Edits v311r0 (675,103 Records) 38765/0213T--63277/G0471 (ZIP) - Effective April 1, 2025;
Posted March 5, 2025

Practitioner PTP Edits v311r0 (571,248 Records) 63278/0213T--U0003/U0004 (ZIP) - Effective April 1, 2025;
Posted March 5, 2025

- 0: Indicates no circumstances in which modifier would be appropriate. Services represented by code combination will not be paid separately
- 1: Indicates modifier is allowed in order to differentiate between services provided
- 9: Indicates edits are no longer active, code combinations are billable, and no modifier is needed

Scenario One, Step Seven

- One lesion is excised and another biopsied
  - Look Medicare NCCI Procedure to Procedure (PTP) Edits
- Separate procedure should not be reported unless distinct and separate
- Claim shall contain modifier for distinct procedural service
- Active wound care code 97597 bundled with 97164, 97605, 97606, 97607, 97608 and 97610
  - Look Medicare NCCI Procedure to Procedure (PTP) Edits
- Separate procedure should not be reported unless unusual circumstances exist and may be honored on appeal

Scenario Two, Step Seven

- YAG capsulotomy left eye (66821) and cataract surgery on right eye (66984)
  - Look Medicare NCCI Procedure to Procedure (PTP) Edits
- Claim shall contain modifier for distinct procedural service
- How would you submit claim?
  - 66984 RT
  - 66821 59 LT

Step Seven, NCCI/PTP Wrap-up

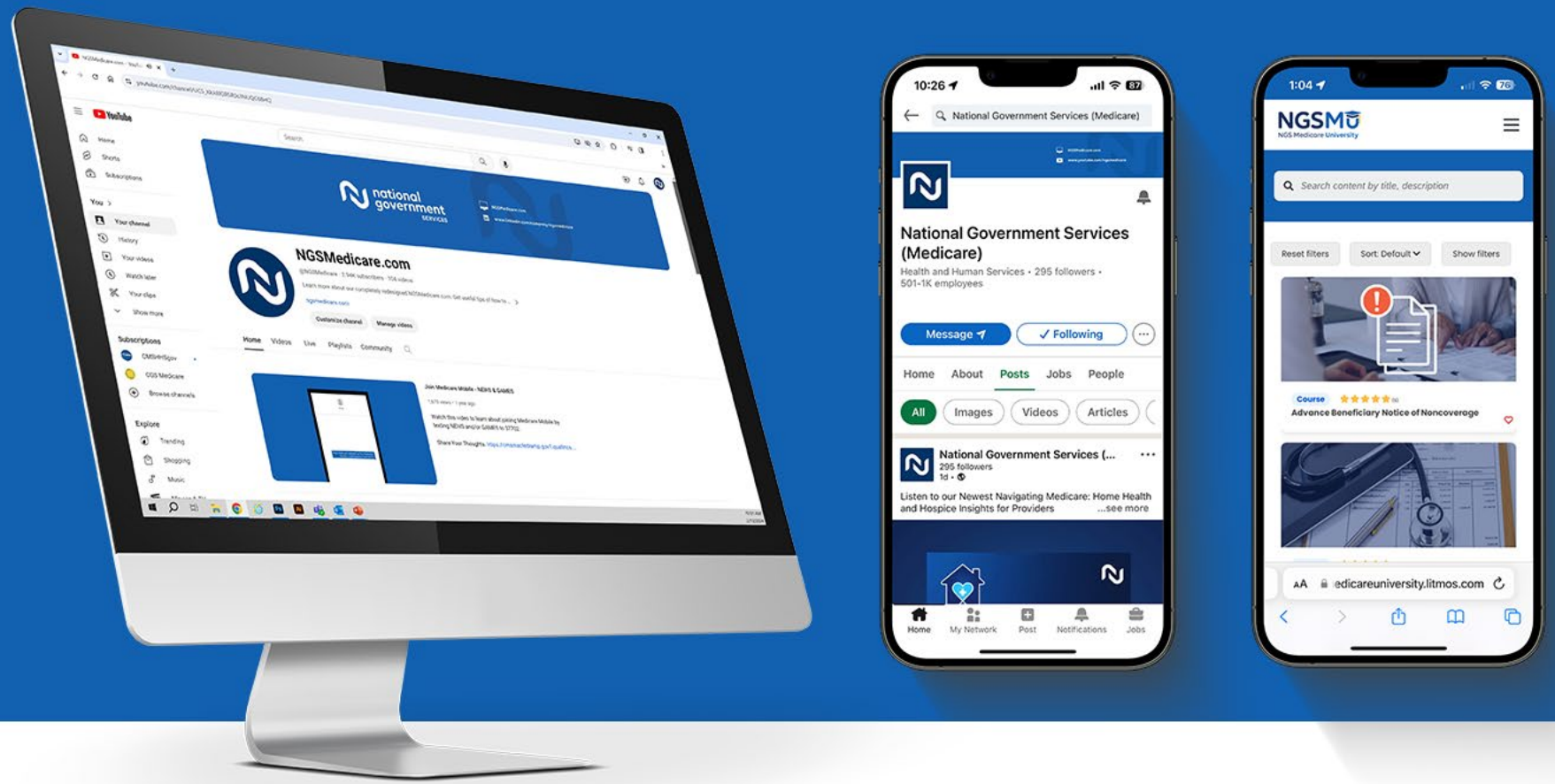
- Review of coding pairs prior to submitting claims
- Submit inquiries about NCCI program, including those related to NCCI (PTP, MUE and add-on code) edits, in writing via email to
  - NCCIPTPMUE@cms.hhs.gov
- Use tables prior to submitting claims

Questions For All

- What is the biggest clerical error reopening or Redetermination issues for your practice?
- What causes you administrative burden?

Questions?

Thank you!



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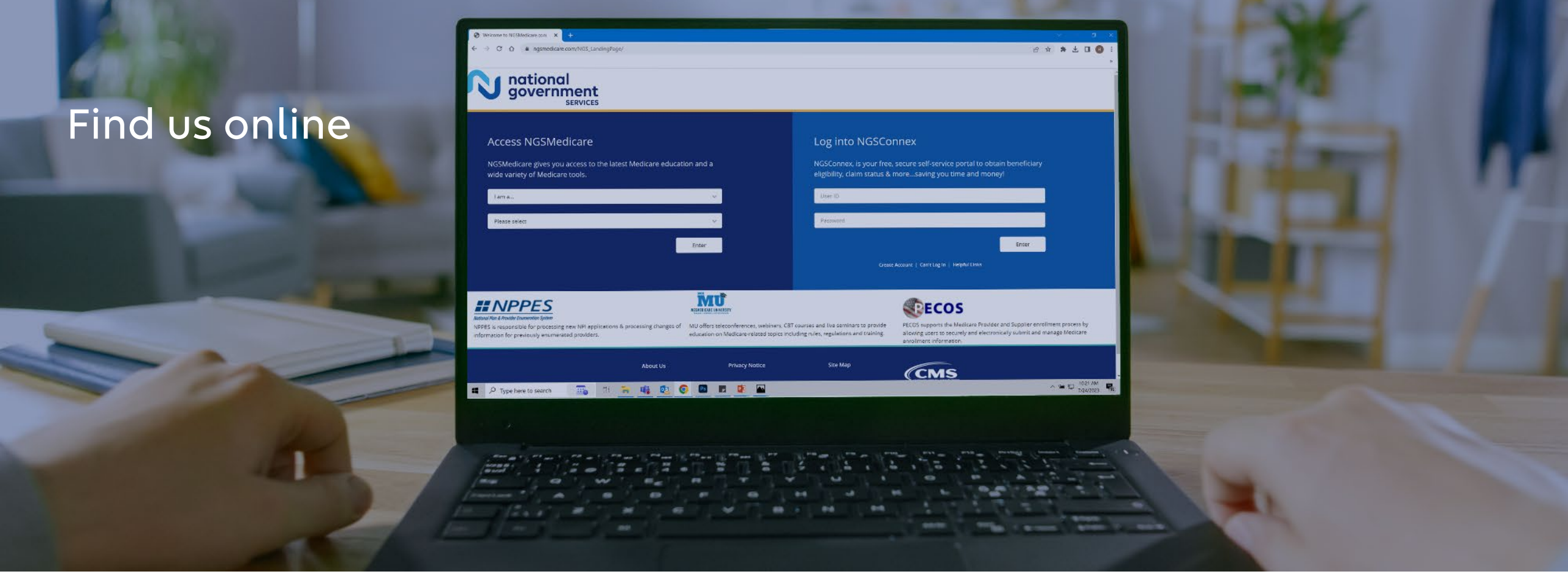

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