Part B Insider (Multispecialty) Coding Alert

Billing: CMS to Institute Payment Edits for E/M Services During Global

When RACs find massive errors, MACs listen.

Starting this July, modifiers will be more important than ever for E/M services you perform during surgical global periods. That's because CMS is taking a cue from the recovery audit contractors (RACs) and will soon be putting edits on your claims for these services to reduce improper payments.

According to two separate CMS transmittals (1051 and 1052, both updated last week), CMS reviewed the issues that RACs identified as the sources of "significant improper payments" and the agency hopes that new edits will cut down on these problems. CMS highlighted the following topics as targets of the upcoming edits, which you'll begin to see in action this summer.

1. E/M Services Performed During the Global Period. Medicare includes most E/M services performed during the global period of surgical services with global days of 000, 010, and 090 in the surgical payment. MACs will be reviewing claims to ensure that any E/M services billed during the global period were medically necessary and valid for separate payment.

In many cases, any E/M services that you deem as separately payable will require a modifier such as 24 (Unrelated evaluation and management service by the same physician during a postoperative period) or 57 (Decision for surgery). However, with the news that MACs will be focusing on these services, be sure that your documentation supports the separate E/M before billing.

2. Untimed Therapy Codes. RAC auditors found a significant number of overpayments on claims with untimed codes, and CMS intends to institute an edit "that denies these codes when billed more than once per day without appropriate modifiers."

For instance, if you report 92526 (Treatment of swallowing dysfunction and/or oral function for feeding) more than once in a day "without appropriate modifiers," your second and subsequent line items will be denied, Transmittal 1051 states. "For untimed codes, units are reported based on the number of times the procedure is performed, as described in the HCPCS code definition (often once per day)," the transmittal adds.

3. E/M With Pulmonary Diagnostic Testing. Starting in July, if you report a pulmonary diagnostic procedure (94010-94799) with an E/M service and you don't append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service), Medicare will deny the E/M service. Although CCI does not currently have an edit in place to support this denial, it's expected that the next round of edits will include one.

"If a physician in attendance for a pulmonary diagnostic procedure obtains a history and performs a physical examination related to the pulmonary diagnostic testing, separate reporting of an evaluation and management service is not appropriate," Transmittal 1052 says. If you perform a significant, separately identifiable E/M service, however, you can still append modifier 25 to represent that, but be sure that your documentation supports it.

4. Initial IV Hydration Codes. If your practitioner performs initial IV hydration (represented by codes such as 96413, 96365, and 96369), you should report the initial code for the first infusion lasting up to one hour, but you shouldn't bill additional "initial" codes "unless protocol requires that two separate IV sites must be used," CMS states. In most cases, you'll report one initial code and, when necessary, one "subsequent infusion" code (such as +96370).

Caveat: If the patient needs two separate IV lines, the physician can report the second service with another unit of the initial code, but must append modifier 59 (Distinct procedural service), CMS says in the transmittal.

5. Modifier 62. The RACs found that in many cases, when two surgeons performed surgery together on the same patient, one surgeon appended modifier 62 (Two surgeons) to her claim while the other doctor did not. Going forward, CMS will ensure that claims for modifier 62 are paid only when both physicians append modifier 62, and when the medical necessity for both surgeons is documented in the medical record.

To read more about the new CMS edits that will start in July, visit http://www.cms.gov/transmittals/downloads/R1052OTN.pdf and http://www.cms.gov/transmittals/downloads/R1051OTN.pdf.