

PART B



Anesthesia Billing Guide

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NHIC, Corp.

J14 A/B MAC

Anesthesia Billing Guide

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INTRODUCTION

The Provider Outreach and Education Team at NHIC, Corp. developed this guide to provide you with Medicare Part B Anesthesia billing information. It is intended to serve as a useful supplement to other manuals published by NHIC, and not as a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from the Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by the CMS, are revised or implemented.

This information guide, in conjunction with the NHIC website (www.medicarenhic.com), J14 A/B MAC Resource (monthly provider newsletter), and special program mailings, provide qualified reference resources. We advise you to check our website for updates to this guide. To receive program updates, you may join our mailing list by clicking on "Join Our Mailing List" on our website. Most of the information in this guide is based on Publication 100-04, Chapter 12 of the CMS Internet Only Manual (IOM). The CMS IOM provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at <http://www.cms.gov/manuals/>

If you have questions or comments regarding this material, please call the Customer Service Center at 866-801-5304.

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GENERAL INFORMATION

A Physician, a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant under the medical supervision of a physician, may provide anesthesia services.

Provider Qualifications

Physician – Anesthesiologist

Physician is defined as a doctor of medicine who is legally authorized to practice in the State in which he/she performs services. The issuance of a license by a State to practice constitutes legal authorization. If the State licensing law limits the scope of practice of a particular type of medical practitioner, only the services within these limitations are covered.

Anesthesiologist Assistants and Certified Registered Nurse Anesthetists

For payment purposes, qualified anesthetists are Anesthesiologist Assistants and Certified Registered Nurse Anesthetists (CRNAs).

An Anesthesiologist Assistant is a person who:

- Is permitted by state law to administer anesthesia; and
- Has successfully completed a six (6) year program for Anesthesiologists Assistants of which two (2) years consist of specialized academic and clinical training in anesthesia.

A CRNA is a registered nurse who is licensed by the state in which the nurse practices and who:

- Is currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists; or
- Has graduated within the past 18 months from a nurse anesthesia program meeting the standards of the Council of Accreditation of Nurse Anesthesia Educational Programs and awaits initial certification.

CRNAs and AAs may bill Medicare directly for their services or have payment made to an employer or an entity under which they have a contract. This could be a hospital, physician or Ambulatory Surgical Center.

NOTE: Locum Tenens Arrangements do not apply to CRNAs and Anesthesiologist Assistants.

GROUP PRACTICE

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. The medical record must indicate the services furnished and identify the physicians who furnished them.

NOTE: However, only one member of the group would bill for the entire anesthesia service.

Medical Direction & Temporary Relief

CRNAs/AAs providing anesthesia services under the medical direction of an anesthesiologist must have uninterrupted immediate availability of an anesthesiologist at all times. When a medically directing anesthesiologist provides temporary relief to another anesthesia provider, the need for uninterrupted immediate availability may be met by any of the following strategies:

- A second anesthesiologist, not medically directing more than three concurrent procedures, may assume temporary medical direction responsibility for the relieving anesthesiologist. The transfer of responsibility from one physician to another should be documented in the medical record.
- Policy and procedure may require that the relieved provider remain in the immediate area and be available to immediately return to his/her case in the event the relieving anesthesiologist is required elsewhere. Adequate mechanisms for communication among staff must be in place.
- Policy and procedure requires that a specified anesthesiologist (e.g., O.R. Director) remain available at all times to provide substitute medical direction services for anesthesiologist(s) providing relief to anesthesia providers. This individual must not personally have ongoing medical direction responsibilities that would preclude temporarily assuming responsibility for additional case(s).

Personally Performed

The following criterion applies to anesthesia services personally performed:

- The physician personally performed the entire anesthesia service alone;
- The physician is a teaching physician and is involved with one anesthesia case with a resident;
- The physician is continuously involved in a single case involving a student nurse anesthetist;
or
- The physician and the non medically directed CRNA (or Anesthesiologist Assistant) are involved in one anesthesia case and the services of each are found to be medically necessary.

Medical Direction

Medical direction occurs if the physician medically directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities:

- Performs a pre-anesthesia examination and evaluation;
- Prescribes the anesthesia plan;
- Personally participates in the most demanding procedures of the anesthesia plan, including induction and emergence, if applicable;
- Ensures that any procedures in the anesthesia plan that he/she does not perform are performed by a qualified anesthetist;
- Monitors the course of anesthesia administration at frequent intervals;

- Remains physically present and available for immediate diagnosis and treatment of emergencies; and
- Provides indicated post-anesthesia care.

The physician can medically direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents or combinations of individuals. The medical direction rules apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern or resident.

For medical direction services, the physician must document in the medical record that he or she performed the pre-anesthetic exam and evaluation. Physicians must also document that they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, if applicable.

Medically Supervised

When an anesthesiologist is involved in rendering more than four procedures concurrently or is performing other services, except as outlined on pages 9 and 10, while directing the concurrent procedures, the anesthesia services are considered medically supervised.

ANESTHESIA SERVICES

Medical and Surgical Services Rendered in Addition to Anesthesia Procedures

Payment may be made under the fee schedule for specific medical and surgical services by the anesthesiologist as long as these services are reasonable and medically necessary or provided other rebundling provisions do not preclude separate payment. These services may be rendered in conjunction with the anesthesia procedure to the patient or as single services (e.g., during the day of or the day before the anesthesia service). These services include the insertion of a Swan-Ganz catheter, the insertion of central venous pressure lines, emergency intubations, and critical care visits.

Anesthesia Services Furnished by the Same Physician Providing the Medical and Surgical Service

Physicians who both perform and provide moderate sedation for medical/surgical services will be paid for the conscious sedation consistent with CPT guidelines. However, physicians who perform, and provide local or minimal sedation for these procedures will not be paid separately for the sedation services.

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The continuum of complexity in anesthesia services (from least intense to most intense) ranges from 1) local or topical anesthesia, 2) moderate (conscious) sedation, 3) regional anesthesia, to 4) general anesthesia. Moderate sedation is a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. It does not include minimal sedation, deep sedation or monitored anesthesia care.

In the past, the *Medicare Claims Processing Manual* instructed contractors not to allow separate payment for the anesthesia service performed by the same physician who furnishes the medical or surgical services (for example, there is no separate payment allowed for a surgeon's performance of a local or surgical anesthesia if the surgeon also performs the surgical procedure; or a psychiatrist's performance of the anesthesia service associated with the electroconvulsive therapy if the psychiatrist performs the electroconvulsive therapy).

Prior to 2006, Medicare did not recognize separate payment if the same physician both performed the medical or surgical procedure and provided the anesthesia needed for the procedure. The final physician fee schedule published in the Federal Register on November 21, 2005 included newly created codes (99143 to 99150) for moderate (conscious) sedation, which the CPT added in 2006.

The revised policy, effective January 1, 2006 and implemented October 1, 2007 is: If the physician performing the procedure also provides moderate sedation for the procedure, then payment may be made for conscious sedation consistent with CPT guidelines; however, if the physician performing the procedure provides local or minimal sedation for the procedure, then no separate payment is made for the local or minimal sedation service.

Contractors will not allow payment for codes 99148-99150 if any of these codes are performed on the same day with a medical/surgical service listed in Appendix G of CPT (Summary of CPT Codes That Include Moderate (Conscious) Sedation) and the service is provided in a non-facility setting. A facility is defined as one with a place of service code of 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56, or 61.

Note: These codes have been assigned a status indicator of "C" under the Medicare physician fee schedule designating that these services are carrier priced. CMS has not established relative value units for these services.

Three of these codes (99143, 99144, and 99145) describe the scenario in which the same physician performing the diagnostic or therapeutic procedure provides the moderate sedation, and an independent trained observer's presence is required to assist in the monitoring of the patient's level of consciousness and physiological status. The other three codes (99148, 99149, and 99150) describe the scenario in which the moderate sedation is provided by a physician other than the one performing the diagnostic or therapeutic procedure.

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Some specific points that you should be aware of:

- CPT coding guidelines for conscious sedation codes instruct practices not to report Codes 99143 to 99145 in conjunction with the codes listed in CPT Appendix G. NHIC will follow the National Correct Coding Initiative, which added edits in April 2006 that bundled CPT codes 99143 and 99144 into the procedures listed in Appendix G (There are no edits for code 99145; it is an add-on-code and it is not paid if the primary code is not paid.)
- In the unusual event that a second physician (other than the one performing the diagnostic or therapeutic services) provides moderate sedation in the facility setting for the procedures listed in CPT Appendix G, the second physician can bill 99148 to 99150, but cannot report these codes when the second physician performs these services (on the same day as a medical/surgical service) in the non-facility setting.
- If an anesthesiologist or CRNA provides anesthesia for diagnostic or therapeutic nerve blocks or injections, and a different provider performs the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using CPT code 01991. In this case, the service must meet the criteria for monitored anesthesia care. If the anesthesiologist or CRNA provides both the anesthesia service and the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using the conscious sedation code and the injection or block. However, the anesthesia service must meet the requirements for conscious sedation and if a lower level complexity anesthesia service is provided, then the conscious sedation code should not be reported.
- There is no CPT code for the performance of local anesthesia, and as such, payment for this service is considered to be part of the payment for the underlying medical or surgical service. Therefore, if the physician performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation (such as a local or topical anesthesia), then the conscious sedation code should not be reported and the contactor will allow no payment.

When denying claims, as appropriate under this policy, contractors will use the message when the service is bundled into the other service: "Payment is included in another service received on the same day."

Contractors will adjust claims brought to their attention that were not processed in accordance with the Medicare physician fee schedule data base indicators assigned to the conscious sedation codes. Requests for reopening may be submitted to the Written Inquiries Department in your jurisdiction.

Source: MLN Matters article MM5618. Effective date 1/1/2006. Implementation date: 10/1/2007/ MM5618 may be viewed at:
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5618.pdf>

Monitored Anesthesia Care

Monitored anesthesia care involves intraoperative monitoring by a physician or qualified individual under the medical direction of a physician or of the patient's vital physiological signs in the anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of anesthesia care required, administration of any necessary oral or parenteral medications (e.g., atropine, demerol, valium) and provision of indicated post-operative anesthesia care.

Payment is made under the personally performed rate if the physician personally performs the monitored anesthesia care (see **Payment at Personally Performed Rate**). Payment is made under the medically directed payment rate if the physician medically directs four (4) or fewer concurrent cases and the monitored anesthesia care represents one (1) or more of these concurrent cases (see **Payment at Medically Directed Rate**).

Pain Management

Pain Management Consultation

Evaluation and management services for postoperative pain control on the day of surgery are considered part of the usual anesthetic services and are not separately reportable. When medically necessary and requested by the attending physician, hospital visits or consultative services are reportable by the anesthesiologist during the postoperative period. However, normal postoperative pain management, including management of intravenous patient controlled analgesia, is considered part of the surgical global package and should not be separately reported.

Postoperative Pain Control Procedures

When provided principally for postoperative pain control, peripheral nerve injections and neuraxial (spinal, epidural) injections can be separately reported on the day of surgery using the appropriate CPT procedure with modifier -59 (Distinct Procedural Service) and 1 unit of service. Examples of such procedures include:

62310-62319	Epidural or subarchnoid injections
64415-64416	Brachial plexus injection, single or continuous
64445-64448	Sciatic or femoral injections, single or continuous
64449	Lumbar plexus injections, continuous

These services should not be reported on the day of surgery if they constitute the surgical anesthetic technique.

NOTE: Modifier 59 requires that the medical record substantiate that the procedure or service was a distinct or separate services performed on the same day.

Daily Management of Continuous Pain Control Techniques

Daily hospital management of continuous epidural or subarachnoid drug administration is reported using CPT code 01996 (1 unit of service daily). This code may be reported on the first and subsequent postoperative days as medically necessary.

When continuous block codes 64416, 64446, 64448, or 64449 are reported on the day of surgery, no additional reporting of daily management is permitted during the following ten days (10 day global period). When these injections procedures constitute the main surgical anesthetic and are therefore not separately reported on the day of surgery, subsequent days' hospital management is reported using the appropriate hospital visit code (99231-99233).

Anesthesia Services and Teaching Anesthesiologist

If a teaching anesthesiologist is involved in a single procedure with one resident, the anesthesia services will be paid at the personally performed rate. The teaching physician must document in the medical records that he or she was present during all critical (or key) portions of the procedure. The teaching physician's physical presence during only the preoperative or postoperative visits with the beneficiary is not sufficient to receive Medicare payment. If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a non-physician anesthetist, the anesthesiologist's services will be paid at the medically directed rate.

Use modifier GC (Teaching Physician Service) to indicate the service has been performed in part by a resident under the direction of a teaching physician. This modifier is added after the anesthesia modifier.

Non-Covered Anesthesia Services

The following anesthesia services are non-covered:

- Stand By

PAYMENT AND REIMBURSEMENT

Payment at Personally Performed Rate

The fee schedule payment for a personally performed procedure is based on the full base unit and one time unit per 15 minutes of service if the physician personally performed the entire procedure. Modifier AA is appropriate when services are personally performed.

Payment at Medically Directed Rate

When the physician is medically directing a qualified anesthetist (CRNA, Anesthesiologist Assistant) in a single anesthesia case or a physician is medically directing 2, 3, or 4 concurrent procedures, the payment amount for each is 50% of the allowance otherwise recognized had the service been performed by the physician alone.

These services are to be billed as follows:

1. The physician should bill using modifier QY, medical direction of one CRNA by a physician or QK, medical direction of 2, 3, or 4 concurrent procedures.
2. The CRNA/Anesthesiologist Assistant should bill using modifier QX, CRNA service with medical direction by a physician.

Payment at Non-Medically Directed Rate

In unusual circumstances, when it is medically necessary for both the anesthesiologist and the CRNA/Anesthesiologist Assistant to be completely and fully involved during a procedure, full payment for the services of each provider are allowed. Documentation must be submitted by each provider to support payment of the full fee.

These services are to be billed as follows:

1. The physician should bill using modifier AA, anesthesia services personally performed by anesthesiologist, and modifier 22, with attached supporting documentation.
2. The CRNA/Anesthesiologist Assistant should bill using modifier QZ, CRNA/Anesthesiologist Assistant services; without medical direction by a physician, and modifier 22, with attached supporting documentation.

Payment at Medically Supervised Rate

Only three (3) base units per procedure are allowed when the anesthesiologist is involved in rendering more than four (4) procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit can be recognized if the physician can document he/she was present at induction. Modifier AD is appropriate when services are medically supervised.

Payment Rules

The fee schedule allowance for anesthesia services is based on a calculation that includes the anesthesia base units assigned to each anesthesia code, the anesthesia time involved, and appropriate area conversion factor. The following formulas are used to determine payment:

- **Participating Physician not Medically Directing (Modifier AA)**
(Base Units + Time Units) x Participating Conversion Factor = Allowance
- **Non-Participating Physician not Medically Directing (Modifier AA)**
(Base Units + Time Units) x Non-Participating Conversion Factor = Allowance
- **Participating Physician Medically Directing (Modifier QY, QK)**
(Base Units + Time Units) x Participating Conversion Factor = Allowance x 50%
- **Non-Participating Physician Medically Directing (Modifier QY, QK)**
(Base Units + Time Units) x Non-Participating Conversion Factor = Allowance x 50%
- **Non-Medically Directed CRNA (Modifier QZ)**
(Base Units + Time Units) x Participating Conversion Factor = Allowance
- **CRNA Medically Directed (Modifier QX)**
(Base Units + Time Units) x Participating Conversion Factor = Allowance x 50%

Concurrent Medically Directed Procedures

Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether the other procedures overlap each other. Concurrency is not dependent on each of the cases involving a Medicare patient. For example, if an anesthesiologist directs three concurrent procedures, two of which involve non-Medicare patients and one Medicare patient, this represents three (3) concurrent cases.

The following example illustrates this concept and guides physicians in determining how many procedures are directed:

Procedures A through E are medically directed procedures involving CRNAs. The starting and ending times for each procedure represent the periods during which anesthesia times are counted.

Procedure A begins at 8:00AM and ends at 8:20AM
Procedure B begins at 8:10AM and ends at 8:45AM
Procedure C begins at 8:30AM and ends at 9:15AM
Procedure D begins at 9:00AM and ends at 12:00 noon
Procedure E begins at 9:10AM and ends at 9:55AM

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Procedure	Number of Concurrent Medically Directed Procedures	Base Unit Reduction Percentage
A	2	10%
B	2	10%
C	3	25%
D	3	25%
E	3	25%

A physician who is concurrently directing the administration of anesthesia to not more than four (4) surgical patients cannot ordinarily be involved in rendering additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous monitoring of an obstetrical patient, does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to the surgical patients. It does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature. No fee schedule payment is made.

The examples listed above are not intended to be an exclusive list of allowed situations. It is expected that the medically-directing anesthesiologist is aware of the nature and type of services he or she is medically directing, and is personally responsible for determining whether his supervisory capacity would be diminished if he or she became involved in the performance of a procedure. It is the responsibility of this medically-directing anesthesiologist to provide services consistent with these regulations.

Base Units

Each anesthesia code (procedure codes 00100-01999) is assigned a base unit value by the American Society of Anesthesiologists (ASA) and used for the purpose of establishing fee schedule allowances.

Anesthesia services are paid on the basis of a relative value system, which include both base and actual time units. Base units take into account the complexity, risk, and skill required to perform the service.

For the most current list of base unit values for each anesthesia procedure code can be found on the Anesthesiologist Center page on the CMS website at:

<http://www.cms.hhs.gov/center/anesth.asp>

Time Units

Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care.

Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time for services furnished, the practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

For anesthesia claims, the elapsed time, in minutes, **must** be reported. Convert hours to minutes and enter the total minutes required for the procedure in Item 24G of the CMS-1500 claim form or electronic media claim equivalent.

Time units for physician and CRNA services - both personally performed and medically directed are determined by dividing the actual anesthesia time by 15 minutes or fraction thereof. Since only the actual time of a fractional unit is recognized, the time unit is rounded to one decimal place. The table below illustrates the conversion from minutes to units used by the carrier for processing:

<u>Minutes</u>	<u>Units</u>	<u>Minutes</u>	<u>Units</u>
1-2	0.1	16-17	1.1
3	0.2	18	1.2
4-5	0.3	19-20	1.3
6	0.4	21	1.4
7-8	0.5	22-23	1.5
9	0.6	24	1.6
10-11	0.7	25-26	1.7
12	0.8	27	1.8
13-14	0.9	28-29	1.9
15	1.0	30	2.0

NOTE: Time Units are not recognized for CPT codes 01995 (Regional IV administration of local anesthetic agent or other medication (upper or lower extremity)) and 01996 (Daily hospital management of epidural or subarachnoid continuous drug administration).

Conversion Factors

Current anesthesia conversion factors can be found on the NHIC website at:

http://www.medicarenhic.com/ne_prov/fee_sched.shtml

Multiple Anesthesia Procedures

Payment may be made under the fee schedule for anesthesia services associated with multiple surgical procedures or multiple bilateral procedures. Payment is based on the base unit of the anesthesia procedure with the highest base unit value and the total time units based on the multiple procedures with the exception of the new add-on codes. On the CMS-1500 claim form, report the anesthesia procedure code with the highest base unit value in Item 24D. In Item 24G, indicate the total time for all the procedures performed.

Add-On Codes

Add-on codes exist for anesthesia involving burn excisions or debridement and obstetrical anesthesia. The add-on code is billed in conjunction to the primary anesthesia code. In the burn area, code 01953 is used in conjunction with code 01952. In the obstetrical area, code 01968 or 01969 is used in conjunction with code 01967. All anesthesia time should be reported only with the primary anesthesia code involving burn excisions or debridement. Anesthesia time for the obstetrical codes should be reported separately on the primary code and the add-on code.

BILLING AND CODING

Billing Instructions

Claims must be submitted on the claim Form CMS-1500 or electronic media claim equivalent. The following are specific to anesthesia claims submission:

- Item 24D – the appropriate anesthesia modifier must be reported
- Item 24G – the actual anesthesia time, in minutes, must be reported.

Modifiers

Anesthesia modifiers must be used with anesthesia procedure codes to indicate whether the procedure was personally performed, medically directed, or medically supervised.

AA	Anesthesia services personally performed by the anesthesiologist
AD	Medical supervision by a physician; more than four concurrent anesthesia services
G8	Monitored anesthesia care (an informational modifier, does not affect reimbursement)
G9	MAC for at risk patient (an informational modifier, does not affect reimbursement)
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals

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QS	Monitored anesthesia care (an informational modifier, does not affect reimbursement)
QX	CRNA service with medical direction by a physician
QY	Medical direction of one CRNA by a physician
QZ	CRNA service without medical direction by a physician

NOTE: Medicare does not recognize Physical Status P modifiers.

NOTE : Modifier QS versus Modifiers G8 or G9 should be used for Monitored Anesthesia Care.

NATIONAL CORRECT CODING INITIATIVE

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

For the NCCI Policy Manual and the latest version of the NCCI Edits refer to the following web site: <http://www.cms.gov/NationalCorrectCodInitEd/>

If you have concerns regarding specific NCCI edits, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907

MEDICALLY UNLIKELY EDITS

The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a 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. The published MUE will consist of most of the codes with MUE values of 1-3. CMS will update the MUE values on its website on a quarterly basis. Although CMS publishes most MUE values on its website, other MUE values are confidential and are for CMS and CMS Contractors' use only. The latter group of MUE values should not be released since CMS does not publish them. For the latest version of the MUEs, refer to:

http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

If you have concerns regarding specific MUEs, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907
Carmel, IN 46082-0907

LIMITATION OF LIABILITY (ADVANCE BENEFICIARY NOTICE)

Services denied as not reasonable and medically necessary, under section 1862(a)(1) of the Social Security Act, are subject to the Limitation of Liability (Advance Beneficiary Notice (ABN)) provision. The ABN is a notice given to beneficiaries to convey that Medicare is not likely to provide coverage in a specific case. Providers must complete the ABN and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice.

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the provider must retain the original notice on file.

Complete instructions and the ABN form (CMS-R-131) can be found on the CMS website at the following address: <http://www.cms.gov/BNI/>

ABN Modifiers

- GA Waiver of liability statement issued, as required by payer policy
- GX Notice of liability issued, voluntary under payer policy
- GY Item or service statutorily excluded or does not meet the definition of any Medicare benefit
- GZ Item or service expected to be denied as not reasonable and necessary (forgot to issue ABN to patient)

LOCAL COVERAGE DETERMINATION (LCD)

Local Coverage Determinations are developed by the local Medicare contractor in the absence of a national Medicare payment policy. These policies describe specific criteria which determine whether an item or service is covered by Medicare and under what circumstances. LCDs are updated as new information and technology occurs in the field of medicine. NHIC has Local Coverage Determinations providing guidelines for various types of services. The LCDs can be found on the CMS website. The links for each state can be found on our website at:

http://www.medicarenhic.com/ne_prov/policies.shtml

NATIONAL COVERAGE DETERMINATION (NCD)

National Coverage Determinations are policies developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. NCDs are the same for all contractors across the country. More information about national coverage can be obtained through this website: <http://www.cms.gov/mcd/search.asp>

MEDICARE FRAUD AND ABUSE

As the CMS J14 A/B MAC for Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, NHIC fully supports the CMS initiative for program safeguards and shares the following information for your use:

Fraud is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent line of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms. Some examples include:

- Billing for services or supplies that were not provided;
- Misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished;
- Altering a claim form to obtain a higher amount paid;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider; and
- Use of another person's Medicare card to obtain medical care.

Abuse describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse takes such forms as, but is not limited to:

- Unbundled charges;
- Excessive charges;
- Medically unnecessary services; and
- Improper billing practices.

Although these practices may initially be considered as abuse, under certain circumstances they may be considered fraudulent. Any allegations of potential fraud or abuse should be referred to Safeguard Services (SGS).

If you wish to report fraud, or have any questions on Medicare Fraud and Abuse, please contact:

Maureen Akhouzine, Manager
Safeguard Services (SSG)
75 William Terry Drive
Hingham, MA 02043
Phone 1-781-741- 3282
Fax 1-781-741-3283
maureen.akhouzine@hp.com

A single number to report suspected fraud is the national OIG fraud hot line: **1-800-HHS-TIPS (1-800-447-8477)**. Information provided to hotline operators is sent out to state analysts and investigators.

RECOVERY AUDIT CONTRACTOR

The Centers for Medicare & Medicaid Services (CMS) has retained Diversified Collection Services (DCS) to carry out the Recovery Audit Contracting (RAC) program for Region A. The RAC program is mandated by Congress aimed at identifying Medicare improper payments. As a RAC, DCS will assist CMS by working with providers in reducing Medicare improper payments through the efficient detection and recovery of overpayments, the identification and reimbursement of underpayments and the implementation of actions that will prevent future improper payments. For more information please click on <http://www.dcsrac.com/>

COMPREHENSIVE ERROR RATE TESTING

In an effort to determine the rate of Medicare claims that are paid in error, CMS developed the Comprehensive Error Rate Testing (CERT) program. This program will determine the paid claim error rates for individual Medicare contractors, specific benefit categories, and the overall national error rate. This is accomplished by sampling random claims on a nationwide basis, while insuring that enough claims are sampled to evaluate the performance of each Medicare contractor. The CERT program is administered by two contractors:

CERT DOCUMENTATION CONTRACTOR (CDC) - The CDC requests and receives medical records from providers.

CERT REVIEW CONTRACTOR (CRC)-The CRC's medical review staff reviews claims that are paid and validate the original payment decision to ensure that the decision was appropriate. The sampled claim data and decisions of the independent medical reviewers will be entered into a tracking and reporting database.

The outcomes from this project are a national paid claims error rate, a claim processing error rate, and a provider compliance rate. The tracking database allows us to quickly identify emerging trends.

Anesthesia Billing Guide

For more information please click on <http://www.cms.gov/CERT/>

TELEPHONE AND ADDRESS DIRECTORY

Provider Interactive Voice Response (IVR) Directory

All actively enrolled providers must utilize the IVR for: **Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date**. The IVR can also assist you with the following information: Seminars, Telephone Numbers, Addresses, Medicare News and Appeal Rights.

CMS requires the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last 5-digits of the tax identification number (TIN) or SSN of the provider to utilize the IVR system.

Available 24 hours/day, 7 days/week (including holidays)

888-248-6950

Provider Customer Service Directory

Our Customer Service representatives will assist you with questions that cannot be answered by the IVR, such as policy questions, specific claim denial questions, 855 application status, and redetermination status. Per CMS requirements, the Customer Service representatives may **not** assist providers with Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date unless we are experiencing IVR system problems.

Hours of Operation:

8:00 a.m. to 4:00 p.m. Monday - Thursday

10:00 a.m. to 4:00 p.m. - Friday

866-801-5304

Dedicated Reopening Requests Only

Hours of Operation:

8:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. Monday - Thursday

10:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. - Friday

877-757-7781

MAILING ADDRESS DIRECTORY

Initial Claim Submission Maine	P.O. Box 2323 Hingham, MA 02044
Massachusetts	P.O. Box 1212 Hingham, MA 02044
New Hampshire	P.O. Box 1717 Hingham, MA 02044
Rhode Island	P.O. Box 9203 Hingham, MA 02044
Vermont	P. O. Box 7777 Hingham, MA 02044
EDI (Electronic Data Interchange)	P.O. Box 9104 Hingham, MA 02044
Written Correspondence	P.O. Box 1000 Hingham, MA 02044
Medicare Reopenings and Redeterminations **See note below	P.O. Box 3535 Hingham, MA 02044
Medicare B Refunds	P.O. Box 809150 Chicago, Il 60680-9150
Medicare Secondary Payer (Correspondence Only)	P.O. Box 9100 Hingham, MA 02044
Provider Enrollment	P.O. Box 3434 Hingham, MA 02044
Medicare Safeguard Services	P.O. Box 4444 Hingham, MA 02044

** Reopening requests may be faxed to NHIC at **1-781-741-3534** using the new fax cover sheet that can be downloaded from our Web site:

www.medicarenhic.com

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) Medicare Administrative Contractor:

NHIC, Corp.

Provider Service Line: 1-866-419-9458

Please view the website to find the appropriate address:

<http://www.medicarenhic.com/dme/contacts.shtml>

Reconsideration (Second Level of Appeal)

C2C Solutions, Inc.

QIC Part B North Reconsiderations

P.O. Box 45208

Jacksonville, FL 32232-5208

INTERNET RESOURCES

The Internet is a very valuable tool in researching certain questions or issues. NHIC has a comprehensive website that serves as a direct source to Medicare as well as a referral tool to other related websites that may prove to be beneficial to you.

NHIC, Corp.

<http://www.medicarenhic.com>

Upon entering NHIC's web address you will be first taken straight to the "home page" where there is a menu of information. NHIC's web page is designed to be user-friendly.

We encourage all providers to join our website mailing list. Just click the link on the home page entitled "Join Our Mailing List". You may also access the link directly at:

<http://visitor.constantcontact.com/email.jsp?m=1101180493704>

When you select the "General Website Updates", you will receive a news report every week, via e-mail, letting you know what the latest updates are for the Medicare program. Other Web News selections (Updates, EDI, etc.) will be sent out on an as-needed basis.

Provider Page Menus/Links

From the home page, you will be taken to the License for use of "Physicians' Current Procedural Terminology", (CPT) and "Current Dental Terminology", (CDT). Near the top of the page are two buttons, "Accept" and "Do Not Accept". Once you click "Accept", you will be taken to the provider pages.

On the left side of the web page you will see a menu of topics that are available. Explore each one and bookmark those that you use most often.

Medicare Coverage Database

<http://www.cms.gov/center/coverage.asp>

<http://www.cms.gov/mcd/indexes.asp>

The Medicare Coverage Database is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. It features Local Coverage Determinations (LCDs) developed by Medicare Contractors and National Coverage Determinations (NCDs) developed by CMS. CMS requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice.

Medicare Learning Network

<http://www.cms.gov/MLNGenInfo/>

The Medicare Learning Network (MLN) website was established by CMS in response to the increased usage of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals about Medicare. For courses and information, visit the web site. For a list of the Training Programs, Medicare Learning Network Matters articles and other education tools available, visit the website.

Open Door Forums

<http://www.cms.gov/OpenDoorForums/>

CMS conducts Open Door Forums. The Open Door Forum addresses the concerns and issues of providers. Providers may participate by conference call and have the opportunity to express concerns and ask questions. For more information, including signing up for the Open Door Forum mailing list, visit the website.

Publications and Forms

<http://www.cms.gov/CMSForms/>

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto this website, you can access numerous CMS forms such as:

- Provider Enrollment CMS 855 forms (CMS 855B, 855I, & 855R)
- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Reconsideration (CMS 20033)
- Medicare Managed Care Disenrollment form (CMS 566)

Advance Beneficiary Notice (ABN)

<http://cms.gov/BNI/>

American Medical Association

<http://www.ama-assn.org/>

CMS

<http://www.cms.gov>
<http://www.medicare.gov>

CMS Correct Coding Initiative

<http://www.cms.gov/NationalCorrectCodInitEd/>

CMS Physician's Information
Resource for Medicare

<http://www.cms.gov/center/physician.asp?>

Electronic Prescribing

<http://www.cms.gov/erx incentive/>

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Evaluation and Management Documentation Guidelines

http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp

http://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

Federal Register

<http://www.archives.gov/federal-register>

<http://www.gpoaccess.gov/index.html>

HIPAA

<http://www.cms.gov/HIPAAGenInfo/>

National Provider Identifier (NPI)

<http://www.cms.gov/NationalProvIdentStand/>

NPI Registry

<https://nppes.cms.gov/NPPES/NPIRegistryHome.do>

Physicians Quality Reporting

<http://www.cms.gov/pqri/>

Provider Enrollment, Chain, and Ownership System (PECOS)

http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPag

Provider Enrollment

<http://www.cms.gov/MedicareProviderSupEnroll/>

U.S. Government Printing Office

<http://www.gpoaccess.gov/index.html>

Revision History:

Version	Date	Reviewed By	Approved By	Summary of Changes
1.0	7/06/2010	Susan Kimball	Ayanna Yancey-Cato	Release of document in the new NHIC Quality Portal
2.0	08/30/2010	M. Franco	Ayanna Yancey-Cato	Updated CMS links; updated Refunds bank address
3.0	10/19/10	Susan Kimball	Ayanna Yancey Cato	Updated QIC name

Anesthesia Billing Guide

NHIC, Corp.

**75 Sgt. William Terry Drive
Hingham, MA 02044**

Website:

<http://www.medicarenhic.com>

CMS Websites

<http://www.cms.gov>

<http://www.medicare.gov>