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Michael Repka, MD
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20 F Street, NW, Suite 400
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Dear Dr. Repka:

I thank you for your recent correspondence about problems your members are encountering with National Correct Coding Initiative (NCCI) procedure to procedure (PTP) edits implemented July 1, 2013. We discussed your issues with CMS (Centers for Medicare & Medicaid Services) which owns NCCI and makes all decisions about its contents.

The edits have column two CPT codes 92012 (Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient) and 92014 (Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits) bundled into column one HCPCS/CPT codes that describe surgical procedures with a global period of 000, 010, or 090 days. These edits are based on the CMS *Internet Only Manual*, Publication 100-04 (*Claims Processing Manual*), Chapter 12, Section 40.3.B which requires that A/B MACs have such edits. (For your convenience I am attaching a copy of Section 40.3.)

You and others have reported that CPT codes 92012 and 92014 with attached modifier 25 are not bypassing the NCCI PTP edits as they should. CMS has determined that there is an electronic claims processing system problem that is not allowing modifier 25 to bypass these NCCI edits. Resolution of the claims processing problem lies outside the NCCI program.

CMS is suspending these edits in NCCI version 19.3 scheduled for October 1, 2013 retroactive to July 1, 2013, the implementation date of these edits. CMS has not yet decided how to resolve the claims processing system problem. However, once the problem is resolved, CMS is likely to reimplement these edits. Thus, it would be worthwhile to remind your members of the appropriate use of modifiers 24, 25, and 57 with evaluation and management CPT codes 92002-92014 when billed on the same date of service as a surgical procedure with a global period of 000, 010, or 090 days.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Claims incorrectly denied because the claims processing system did not bypass an NCCI edit when modifier 24, 25, or 57 was appropriately appended to CPT codes 92012 or 92014 when reported on the same date of service as a global surgery procedure may be resubmitted to the local A/B MAC after October 1, 2013. Your members might check with their local A/B MACs for specific instructions.

Your members have the option of delaying submission of future claims for CPT codes 92012 or 92014 when performed on the same date of service as a global surgery procedure until October 1, 2013 when the edits will be suspended.

CMS and we appreciate your assistance with the NCCI.

Sincerely,

Signed electronically by Niles R. Rosen, M.D.

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Cc: Marsha Mason-Wonsley, CMS CPT Coding Specialist
Cherie McNett, Kelsey Kurth, AAO

Enclosure: *Internet Only Manual*, Publication 100-04 (*Claims Processing Manual*), Chapter 12, Section 40.3

C. Care Provided in Different Payment Localities

If portions of the global period are provided in different payment localities, the services should be billed to the carriers servicing each applicable payment locality. For example, if the surgery is performed in one state and the postoperative care is provided in another state, the surgery is billed with modifier "-54" to the carrier servicing the payment locality where the surgery was performed and the postoperative care is billed with modifier "-55" to the carrier servicing the payment locality where the postoperative care was performed. This is true whether the services were performed by the same physician/group or different physicians/groups.

D. Health Professional Shortage Area (HPSA) Payments for Services Which are Subject to the Global Surgery Rules

HPSA bonus payments may be made for global surgeries when the services are provided in HPSAs. The following are guidelines for the appropriate billing procedures:

- If the entire global package is provided in a HPSA, physicians should bill for the appropriate global surgical code with the applicable HPSA modifier.

- If only a portion of the global package is provided in a HPSA, the physician should bill using a HPSA modifier for the portion which is provided in the HPSA.

EXAMPLE

The surgical portion of the global service is provided in a non-HPSA and the postoperative portion is provided in a HPSA. The surgical portion should be billed with the "-54" modifier and no HPSA modifier. The postoperative portion should be billed with the "-55" modifier and the appropriate HPSA modifier. The 10 percent bonus will be paid on the appropriate postoperative portion only. If a claim is submitted with a global surgical code and a HPSA modifier, the carrier assumes that the entire global service was provided in a HPSA in the absence of evidence otherwise.

NOTE: The sum of the payments made for the surgical and postoperative services provided in different localities will not equal the global amount in either of the localities because of geographic adjustments made through the Geographic Practice Cost Indices.

40.3 - Claims Review for Global Surgeries

(Rev. 1, 10-01-03)

B3-4823

A. Relationship to Correct Coding Initiative (CCI)

The CCI policy and computer edits allow carriers to detect instances of fragmented billing for certain intra-operative services and other services furnished on the same day as the surgery that are considered to be components of the surgical procedure and, therefore,

included in the global surgical fee. When both correct coding and global surgery edits apply to the same claim, carriers first apply the correct coding edits, then, apply the global surgery edits to the correctly coded services.

B. Prepayment Edits to Detect Separate Billing of Services Included in the Global Package

In addition to the correct coding edits, carriers must be capable of detecting certain other services included in the payment for a major or minor surgery or for an endoscopy. On a prepayment basis, carriers identify the services that meet the following conditions:

- Preoperative services that are submitted on the same claim or on a subsequent claim as a surgical procedure; or
- Same day or postoperative services that are submitted on the same claim or on a subsequent claim as a surgical procedure or endoscopy;
- and -
- Services that were furnished within the prescribed global period of the surgical procedure;
- Services that are billed without modifier "-78," "-79," "-24," "25," or "-57" or are billed with modifier "-24" but without the required documentation; and
- Services that are billed with the same provider or group number as the surgical procedure or endoscopy. Also, edit for any visits billed separately during the postoperative period without modifier "-24" by a physician who billed for the postoperative care only with modifier "-55."

Carriers use the following evaluation and management codes in establishing edits for visits included in the global package. CPT codes 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99271, 99272, 99273, 99274, and 99275 have been transferred from the excluded category and are now included in the global surgery edits.

Evaluation and Management Codes for Carrier Edits

92012	92014	99211	99212	99213	99214
99215	99217	99218	99219	99220	99221
99222	99223	99231	99232	99233	99234
99235	99236	99238	99239	99241	99242
99243	99244	99245	99251	99252	99253

99254	99255	99261	99262	99263	99271
99272	99273	99274	99275	99291	99292
99301	99302	99303	99311	99312	99313
99315	99316	99331	99332	99333	99347
99348	99349	99350			
99374	99375	99377	99378		

NOTE: In order for codes 99291 or 99292 to be paid for services furnished during the preoperative or postoperative period, modifier "-25" or "-24," respectively, must be used and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930-939), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

If a surgeon is admitting a patient to a nursing facility for a condition not related to the global surgical procedure, the physician should bill for the nursing facility admission and care with a "-24" modifier and appropriate documentation. If a surgeon is admitting a patient to a nursing facility and the patient's admission to that facility relates to the global surgical procedure, the nursing facility admission and any services related to the global surgical procedure are included in the global surgery fee.

C. Exclusions from Prepayment Edits

Carriers exclude the following services from the prepayment audit process and allow separate payment if all usual requirements are met:

Services listed in §40.1.B; and

Services billed with the modifier "-25," "-57," "-58," "-78," or "-79."

Exceptions

See §§40.2.A.8, 40.2.A.9, and 40.4.A for instances where prepayment review is required for modifier "-25." In addition, prepayment review is necessary for CPT codes 90935, 90937, 90945, and 90947 when a visit and modifier "-25" are billed with these services.

Exclude the following codes from the prepayment edits required in §40.3.B.

92002	92004	99201	99202	99203	99204
99205	99281	99282	99283	99284	99285

99321	99322	99323	99341	99342	99343
99344	99345				

40.4 - Adjudication of Claims for Global Surgeries

(Rev. 1, 10-01-03)

B3-4824, B3-4825, B3-7100-7120.7

A. Fragmented Billing of Services Included in the Global Package

Since the Medicare fee schedule amount for surgical procedures includes all services that are part of the global surgery package, carriers do not pay more than that amount when a bill is fragmented. When total charges for fragmented services exceed the global fee, process the claim as a fee schedule reduction (except where stated policies, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative inpatient care, result in payment that is higher than the global surgery allowed amount). Carriers do not attribute such reductions to medical review savings except where the usual medical review process results in recoding of a service, and the recoded service is included in the global surgery package.

The maximum a nonparticipating physician may bill a beneficiary on an unassigned claim for services included in the global surgery package is the limiting charge for the surgical procedure.

In addition, the limitation of liability provision (§1879 of the Act) does not apply to these determinations since they are fee schedule reductions, not denials based upon medical necessity or custodial care.

Claims for surgeries billed with a "-22" or "-52" modifier, are priced by individual consideration if the statement and documentation required by §40.2.A.10 are included. If the statement and documentation are not submitted with the claim, pricing for "-22" is it the fee schedule rate for the same surgery submitted without the "-22" modifier. Pricing for "-52" is not done without the required documentation.

Separate payment is allowed for visits and procedures billed with modifier "-78," "-79," "-24," "-25," "-57," or "-58." Modifier "-24" must be accompanied by sufficient documentation that the visit is unrelated to the surgery. Also, when used with the critical care codes, modifiers "-24" and "-25" must be accompanied by documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed. An ICD-9-CM code in the range 800.0 through 959.9 (except 930-939), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.