A Coders Perspective

What Managers should know about Modifier 25, Incident To and NCCI

Doctors want to get paid for their services

The deck is usually stacked against them

They're stuck between

- The government
  - Regulations
- Insurance Companies
  - Clinical Policies
  - Reimbursement Policies
- Patients
  - Expectations
  - Failure to understand their insurance coverage

How can Coders & Managers Help?

Education and Communication

In addition to coding, coders must understand:

- The billing process
- Government regulations
- Insurance company policies

In addition to the revenue cycle managers must have some knowledge of:

- Coding and billing guidelines
- Government regulations
- Insurance company policies

Modifier 25 & Incident To

What do they have in common?

They are both under scrutiny by the OIG

Their use is often misunderstood

They are overutilized

Let’s Break it down

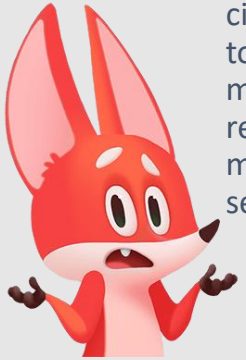
When is modifier 25 appropriate?

Definition of “significantly separate”

Define “incident to”

CPT Description of Modifier 25

- Significantly, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
    - It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptoms or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significantly separate non-E/M services, see modifier 59.



Definitions of Significant & Separately

- Significant
  - Oxford Dictionary
    - “sufficiently great or important to be worthy of attention; noteworthy”
  - Miriam Webster
    - “Having or likely to have influence or effect: Important; of a noticeably or large amount”
- Separately
  - Oxford Dictionary
    - “as a separate entity or entities; not together.”
  - Miriam Webster
    - “in a separate manner or by separate means; not together with someone or something else.”

What's included with a procedure?

- All minor procedures include reimbursement for the pre- and post-operative services that are inherent to the procedure
  - In other words - Some of the E/M work is already included in the payment for the procedure
- Per the AMA CPT Assistant:
- "Pre and post-operative services typically associated with a procedure include the following and cannot be reported with a separate E/M service code:
  - Review of patient's relevant past medical history
  - Assessment of the problem area to be treated by surgical or other service
  - Formulation and explanation of the clinical diagnosis
  - Review and explanation of the procedure to the patient, family, or caregiver
  - Discussion of alternative treatments or diagnostic options
  - Obtaining informed consent
  - Providing post-operative care instructions
  - Discussion of any further treatment and follow-up after the procedure

Medical Decision Making

- Number and Complexity of Problems Addressed (at the present encounter)
- Amount of Data Reviewed and Analyzed
- Risk of Complications, Morbidity and/or Mortality of Patient Management
- Clinically Appropriate History and Exam
- Most important MEDICAL NECESSITY
  - Is it medically necessary to do a separate E/M with this procedure?
- Use of Time
  - Cannot count the time used making the decision for or performing the procedure
- Inconveniencing patients

Level 2 visits (new and established)

- Would a level 2 visit qualify for modifier 25?
  - Does it meet the requirements for significant and separately identifiable?
- Level 2 criteria
  - Medical appropriate history and examination
  - Straightforward Medical Decision Making
- Straightforward Medical Decision Making Criteria
  - Number and Complexity of Problems addressed (at the present encounter)
    - One self limited or minor problem
  - Amount of Data Reviewed and Analyzed
    - Minimal or none
  - Risk of Complications, Morbidity and/or Mortality of Patient Management
    - Minimal risk from additional diagnostic testing or treatment
- Consider only if there is a separate problem
  - Different diagnosis

Preventive Services with a problem visit

- Per the AMA CPT® Assistant
  - If an abnormality is encountered or a preexisting problem is addressed in the process of performing a preventive medicine E/M service, and the problem or abnormality is significant enough to require additional work to perform the key components of a problem oriented E/M service, then the appropriate office or other outpatient visit E/M code should also be reported. Modifier 25 should be appended to the office or other outpatient visit and the appropriate preventive medicine service is reported without a modifier
  - If an insignificant or trivial problem or abnormality is encountered during a preventive medicine E/M service that does not require significant additional work, then a separate office or other outpatient visit code should not be reported
- Significant, separately Identifiable E/M services should be documented
  - A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service
- CPT guidelines do not require a different diagnosis for the E/M Service and the procedure

What about having the patient return?

- CMA does not want the patient inconvenienced

- NCCI Policy Manual
  - The General Policy Statements in each chapter of the NCCI policy Manual has a statement that says:
  - 1. The MUE values and NCCI PTP edits are based on services provided by the same provider/supplier to the same beneficiary on the same date of service. Physicians shall not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.

Is the E/M service provided with an initial decision to perform a major surgery?

Yes → Report the E/M service with modifier 57

No ↓

Does documentation support that the patient's condition required a separate and significant E/M service above and beyond the normal pre-operative and post-operative service for the procedure?

No → Do not bill E/M service with the procedure

Yes ↓

Does the documentation in the medical record support the significant circumstances?

No → Do not bill E/M service with the procedure

Yes ↓

Does the documentation define the medical necessity for the E/M service with the procedure

No → Do not bill E/M service with the procedure

Yes ↓

Submit E/M service with modifier 25 and bill with procedure

Non-physician Practitioners and Incident To Billing

Nurse Practitioner

Physician Assistant

CMS Definition of “Incident To”

- Services or supplies that are furnished incident to a physician’s professional services when the services or supplies are furnished as an integral, although incidental part of the physician’s professional services in the course of diagnosis or treatment of an injury or illness and service are performed in the physician’s office or the patient’s home. To qualify for payment under incident to rules, services must be part of the patient’s normal course of treatment, during which a physician personally performs an initial service and remains actively involved in the ongoing course of treatment

Interpretation?

- The service must take place in the office setting
- The Physician must initiate care and treatment plan
  - Does not apply to new patients
  - Or established patients with new problems
- After initial plan of care NPP may provide follow up care
  - Includes medication adjustments if documented in the original plan
- Physician must actively participate in and manage the course of treatment
- Both physician and NPP must be employed by the same group entity
  - If solo practitioner NPP must be the employee
- Service must be of a type normally performed in an office setting

The future of incident to billing for NPPs

- Medicare Payment Advisory Committee (MedPac) has recommended the elimination
- Both the American Association of Nurse Practitioners and the American Academy of Physician Assistants feel that it
  - Undermines the foundation of value based reimbursement
  - Makes it nearly impossible to accurately identify the type, volume or quality of medical services delivered by PAs and NPS
  - Negatively affects Care Compare scores of PAs and NPs
  - Leads to patient confusion which can cause them to think they need to correct what appears to be erroneous information
- So, who are those payors who don’t allow incident to for NPPS?

Who will pay incident to services?

- Not all carriers allow incident to billing for NPPs

- It’s important to follow carrier guidelines
- So, who are those payors who don’t allow incident to for NPPS?
  - Anthem (commercial and Managed Medicare)
  - CarePartners of CT
  - Cigna
  - Connecticare (commercial)
  - CT Medicaid
  - Harvard Pilgrim
  - Humana (commercial)

Additional 15% -Is It Worth the Risk?

- Each practice needs to determine if the additional payment for billing incident to is worth the risk.
- A cost analysis should be done
  - What does a physician make per hour
  - What does the NPP make per hour
  - What is the reimbursement per CPT code
    - Don’t look at what you charge
    - Will differ based on each insurance company allowable
- You may still make a profit for the encounter example:
  - Physician makes $250/hr
  - NPP makes $55/hr
  - Reimbursement $100
  - Profit from physician is -$150
  - Profit from NPP even at 85% is $45

Penalties for improper billing

- Improper billing of NPPs can be considered a violation of the False Claim Act (among others)
  - Penalties up to $11,000 per claim
  - In addition 3x the damages
  - Fines up to $250,000
  - And up 5 years imprisonment
- May 2019 – Donald Douglas M.D., TX paid $118,000
- January 2020 – Chang-Wen Chen, M.D., TN paid $285,000
- August 2022 – North County Neurology, P.C., NY paid $850,000
- June 2023 – insite Digestive Health Care, California paid $1.7 million

National Correct Coding Initiative

What is it and how does it affect my practice?

The National Correct Coding Initiative

- A program developed by CMS to promote national correct coding of Medicare Part B Claims
- CMS owns the NCCI program and is responsible for all content decisions
- CMS develops the guidelines based on:
  - AMA CPT coding conventions
  - National and local policies and edits
  - National specialty societies' coding guidelines
  - Analysis of standard medical and surgical practices
  - Review of current coding practices
- Many other payors follow these guidelines
- The edits are updated quarterly
- The manual is updated yearly

Types of edits

- NCCI has different types of edits
  - Procedure to procedure (PTP)
  - Add on code
  - Medically unlikely edits (MUE)
- NCCI Policy Manual
  - Not all edits are listed in the PTP edits
  - The policy manual has a General Correct Coding Chapter
  - Chapters that correlate with CPT
- Designated separate procedures
  - Are generally not payable if done at the same patient encounter
  - Can be paid if specific criteria is met

Questions?

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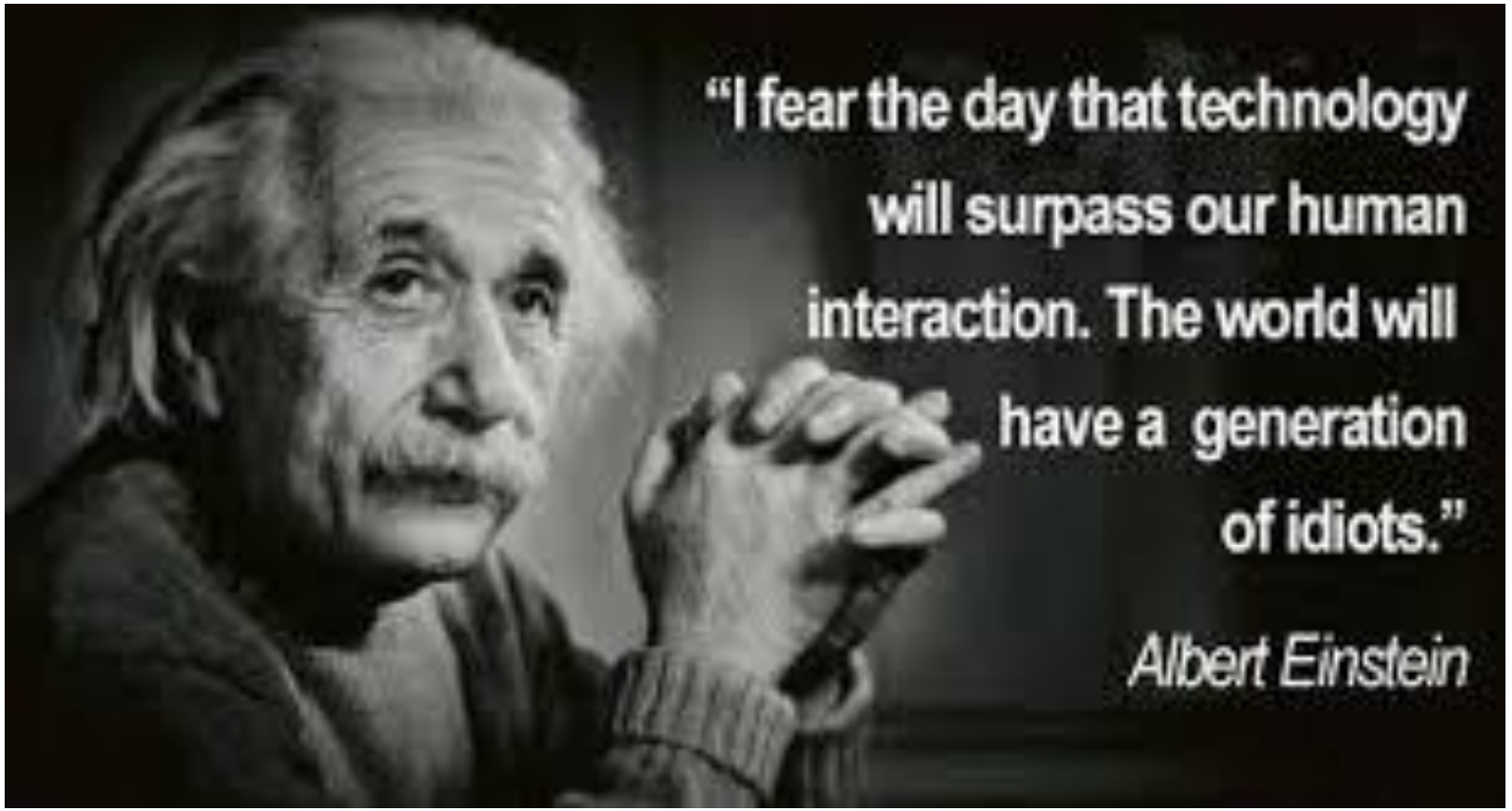
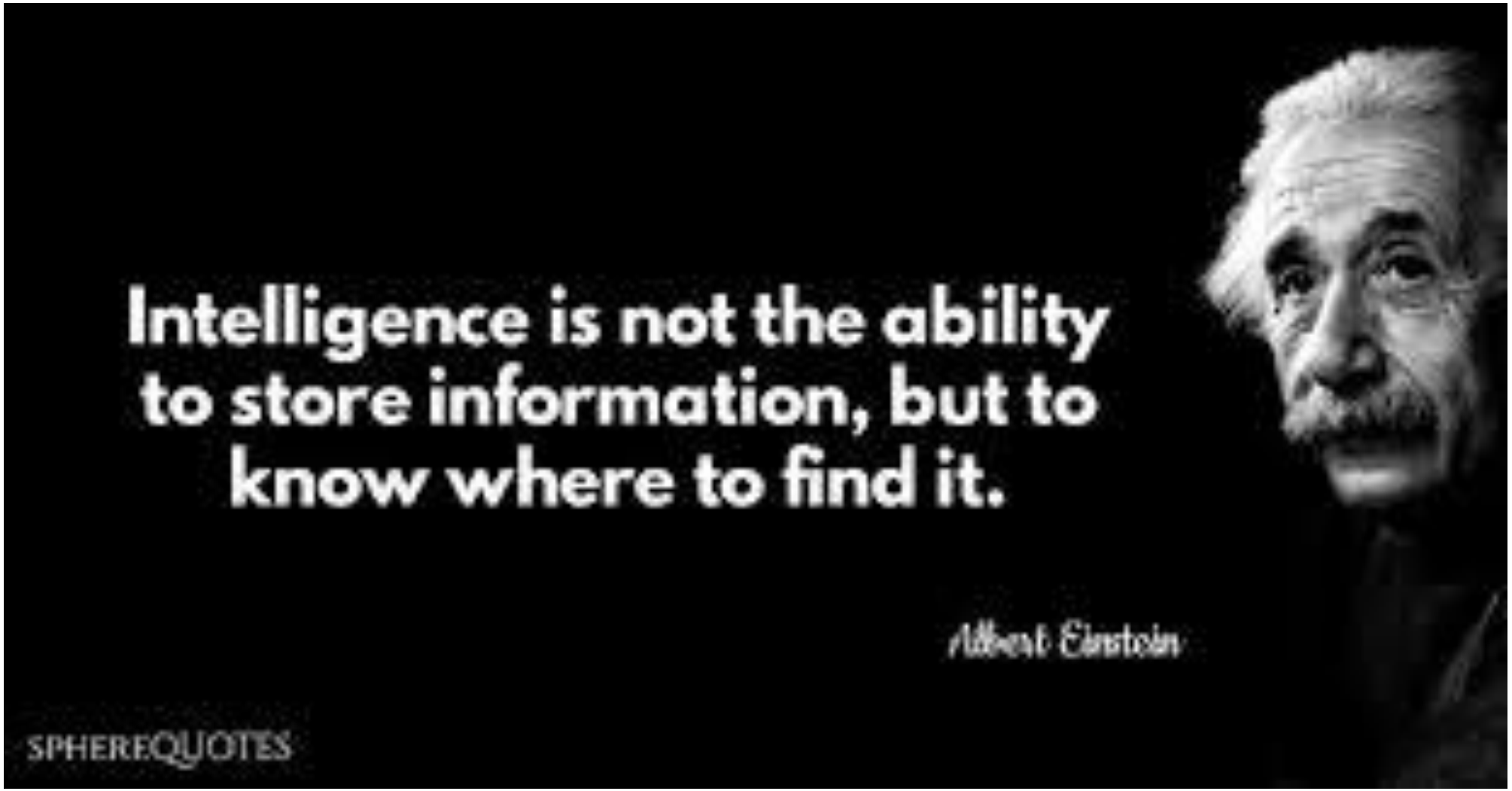

"I fear the day that technology will surpass our human interaction. The world will have a generation of idiots."
Albert Einstein


Intelligence is not the ability to store information, but to know where to find it.
Albert Einstein
SPHEREQUOTES

Resources

- CPT Professional Edition 2023
- AMA CPT E/M Code and Guideline Changes effective 1/1/2023
- Medicare Benefit Policy Manual 100-02, Chapter 15, Section 60.1
- AMA Orthopedic Coding Alert Feb 8 2023
- Indiana State Medial Association Incident To Fact Sheet
- NGS Medicare Incident To Office Guidelines
- WPS Medicare Incident To Services – Documentation and Correct Billing
- Noridian Medicare Incident To Services
- PAs & NPs in Orthopaedics: Rules, Reimbursement and Realities
  - Daniel Coll, MBA, MHS,PA-c, DFAAPA and Dennis Gregory, MPAS, PA-c

Resources

- CMS.gov
- OIG.HHS.gov
- Article from Clinical Advisor, Aug 3,2022 – “Is It Time To End Medicare Indirect Billing For NPs and PAs/”, Kristin Della Volpe