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Maxine Collins
MBA, CPA, CMC, CMIS, CMOM
Faculty
Practice Management Institute

On the topic:
Reasonable and Necessary: Navigating Carrier Coverage
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Reasonable and Necessary
Navigating Carrier Coverage Determinations

Brought to you by
Maxine Collins, MBA, CPA, CMC, CMOM, CMIS
Director of Compliance, Audits and Education,
CoreMD Partners, LLC; Faculty/Consultant
Practice Management Institute®

NAVIGATING CARRIER COVERAGE DETERMINATIONS

• Has your practice received a denial for medical necessity in the past?
• Have you seen any of the following on your EOBs?:
  – “50” “These are non-covered services because this is not deemed a “medical necessity” by the payer. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment) information REF, if present.)

Start: 01/01/1995| Last Modified: 09/20/2009/
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TRANSLATION – CARCs/RARCs!

• The Health Insurance Portability and Accountability Act (HIPAA) of 1996:
  – Medicare policy states Claim Adjustment Reason Codes (CARCs) required in remittance advice and COB transactions.
  – Further states – that appropriate Remittance Advice Remark Codes (RARCs) that provide supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice transaction.
  – These remark codes change occasionally.
  – Codes are posted on the WPC website

TRANSLATION – CARCs/RARCs!

  – Code list is updated 3 x year around March 1, July 1, and November 1 - [http://www.wpc-edi.com/Codes](http://www.wpc-edi.com/Codes)
  – CARCs – maintained by national code maintenance committee which meets Jan/Feb, June and Sept/Oct) and makes decisions about additions, modifications, and retirement of existing codes. New codes usually become effective when published
  – A health plan may decide to implement a code deactivation before the actual effective date posted on WPC website.
EXAMPLE

- 16 - Claim/service lacks information which is needed for adjudication.
- 50 - These are non-covered services because this is not deemed a “medical necessity” by the payer.
  – Should be printed on the Standard Paper Remit or MREP RA or the PC Print RA as shown in previous slide on or after 04/01/2010.
  – CHALLENGE? – KEEPING UP WITH ALL OF THE CHANGES!

Medical Necessity

“Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.”

Per Internet Only Manual (IOM) Medicare Claims Processing Manual, Publication 100-04, Chapter 12, section 30.6.1
Common Errors

- Insufficient Documentation
- Incorrect Coding
- Medical Necessity Not Supported
- Documentation Doesn’t Support Level Billed
- Prolonged Services
- Time-based Services
- Duplicate submissions
- Other Issues

IT NOW TAKES AN “ARMY” TO SECURE ACCURATE REIMBURSEMENT FOR THE PHYSICIAN

CHALLENGES ABOUND!

- Private Carrier Coverage Guidelines and Policies
- Medicare National Coverage Determinations
- Medicare Local Coverage Determinations
- National Correct Coding Initiative Edits
  - Quarterly changes to the over 1,400,000 edits!
- Evaluation and Management Documentation Guidelines
- ICD-10-CM Official Guidelines for Coding and Reporting for 2017 changes
- Decreasing Reimbursement over past few years
- PQRS Reporting Requirements
- Movement to the Value-Based Purchasing Reimbursement System for Both Medicare and Private Carriers.
- Increasing Number of Patients
- Higher costs of providing services
Reasonable & Necessary Guidelines

- In the absence of a LCD (Local Coverage Determination), NCD (National Coverage Determination), or CMS Manual Instruction, Reasonable and Necessary guidelines still apply. Section 1862(a)(1)(A) of the SSA (Social Security Act) directs the following:

  — “No payment may be made under Part A or Part B for any expenses incurred for items or services not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”
HOW ARE WE TO KEEP UP WITH ALL THE CHANGES?

• Reason most often cited for denials of services

• Medicare Carrier Manual:
  – “all services must be medically necessary and medically reasonable for diagnosing and treating an illness or injury or to improve the functioning of a malformed body member ”

INTERPRETATION OF WHAT TREATMENT IS MEDICALLY NECESSARY

• A great challenge for the healthcare professional as each has own opinion on treatment options for specific patients.

• Other complications in defining:
  – Federal and state payors
  – Managed care organizations
  – Specific, acceptable diagnosis codes required under some payor guidelines
A MEDICAL DIRECTOR’S INTERPRETATION

• According to Michael K. Rosenberg, M.D. Carrier Medical Director, Michigan, in his 2002 issue of the Medicare Bulletin for Michigan and Illinois:
  – “The words “not medically necessary” are frequently used in Medicare provider and beneficiary messages and communications. It is a very unfortunate term. It evokes a lot of emotion...
  – The implication inherent in a medical necessity denial is that the diagnostic or therapeutic service provided by the physician, was unnecessary, and, therefore, in some way bad or at the very least superfluous. This has the effect of confusing patients and angering physicians.”


MEDICARE REASONABLE & NECESSARY GUIDELINES

• Therefore, to be considered “reasonable and necessary” the patient’s medical record must clearly document all of the following:
  – The item or service is for the diagnosis or treatment, or to improve the functioning of a malformed body member
  – The item or service is appropriate for the symptoms and diagnosis or treatment of the patient’s condition, illness, disease or injury
  – The item or service is furnished in accordance with current standards of good medical practice
  – The item or service is not primarily for the convenience of the patient, physician, or health care provider

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MEDICARE REASONABLE & NECESSARY GUIDELINES

– The item or service is the most appropriate supply or level of service that can be safely provided to the patient
– The item or service is delivered in the most appropriate setting
– The item or service is ordered and/or furnished by qualified personnel

• For any service reported to Medicare, it is expected that the medical record documentation clearly demonstrates that the service meets all of the above criteria. All documentation must be maintained in the patient’s medical record and be available to the contractor upon request.
NCDs AND LCDs

- Medicare uses: to provide guidelines to allow coverage for services (codes), list limitations of coverage and/or deny coverage for specific procedures, devices or supplies.
  - National Coverage Determinations – NCDs –
    National policy statements that apply to all Medicare claims. NCDs determine the extent and under what circumstances Medicare will cover specific services, procedures, and supplies. The NCDs also provide information on any limitations to coverage and or excluded services covered for the specific code(s) covered by the guidelines.

- Local Coverage Determinations – LCDs (Formerly called LMRPs) are coverage guidelines issued by a MAC (Medicare Administrative Contractor) or Fiscal Intermediary (FI) that apply to the specific providers and services in the region(s) that they are contracted to administer. These will often provide the acceptable and non-acceptable CPT/HCPCS and ICD-10-CM code(s) that will justify medical necessity of a service. In addition, the LCD may provide information concerning limitations, such as frequency of a given test or service to be reimbursed.

- When a physician or other healthcare professional signs the Medicare contract, they are attesting that they will learn and use the appropriate guidelines for coverage if an LCD/NCD exist for the service being billed on the Federal claim form. It is the provider’s responsibility to follow these guidelines.
Welcome to the Medicare Coverage Database

MCD Notice Board

• """"CMS CCSQ is sponsoring a series of four (4) Lunch and Learn Seminars on the MCD. For more information and registration, please click on the following link - Lunch and Learn Webinar Series for MCD """

• Last Updated: 2016-09-07
• Latest Site Updates (PDF, 83 KB, 08/04/2016)
• The Medicare Coverage Database (MCD) contains all National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), local articles, and proposed NCD decisions. The database also includes several other types of National Coverage policy related documents, including National Coverage Analyses (NCAs), Coding Analyses for Labs (CALs), Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) proceedings, and Medicare coverage guidance documents.

• How to Use this Site
• MCD vs. Medicare.gov
• Information about LCDs and LCD Challenges
• The MCD offers multiple ways to locate and view data

PURPOSE FOR NATIONAL COVERAGE DETERMINATIONS (NCDs)

• Statutory and policy framework:
  – Title XVIII of the Social Security Act (the Act); and
  – In Medicare regulations and rulings

• NCD Manual:
  – Describes whether specific medical items, services, treatment procedures, or technologies can be paid for under Medicare.
  – Decisions generally based on paragraph 1862(a)(1) of the Act – the “not reasonable and necessary” exclusion.

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PURPOSE FOR NATIONAL COVERAGE DETERMINATIONS (NCDs)

• Where another statutory authority for denial is indicated, that is the authority for denial.
• Where an item or service is stated to be covered, but such coverage is explicitly limited to specified indications or specified circumstances, all limitations on coverage of the item/services because they do not meet those specified indications or circumstances are based on 1862(a)(1) of the Act.
• Where coverage of an item/service is provided for specified indications or circumstances but is not explicitly excluded for others, or where the item/service is not mentioned at all in the CMS NCD Manual, the Medicare Administrative Contractor (MAC) has the discretion to make the coverage decision, in consultation with its medical staff, and with CMS when appropriate, based on the law, regulations, rulings, and general program instructions.

NDC MANUAL

• Organized by categories:
  – Medical procedures
  – Supplies
  – Diagnostic services
• CMS Coverage Website:
EXAMPLE OF AN NCD: 10.2 TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) FOR ACUTE POST-OPERATIVE PAIN

- (Rev. 173, Issued: 09-04/14, Effective: Upon Implementation: of ICD-10, Implementation)
- Use of TENS for the relief of acute post-operative pain is covered under Medicare.
  - May be covered whether used as an adjunct to the use of drugs, or as an alternative to drugs, in the treatment of acute pain resulting from surgery.
- The TENS devices, whether durable or disposable, may be used in furnishing this service.
  - When used for the purpose of treating acute post-operative pain, TENS devices are considered supplies. As such they may be hospital supplies furnished inpatients covered under Part A, or supplies incident to a physician’s service when furnished in connection with surgery done on an outpatient basis, and covered under Part B.

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EXAMPLE OF AN NCD: 10.2 TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) FOR ACUTE POST-OPERATIVE PAIN

- It is expected that TENS, when used for acute post-operative pain, will be necessary for relatively short periods of time, usually 30 days or less.
  - In cases when TENS is used for longer periods, A/B MACs should attempt to ascertain whether TENS is no longer being used for acute pain but rather for chronic pain, in which case the TENS device may be covered as durable medical equipment as described in paragraph 160.27
- Cross-references:
  - Medicare Benefit Policy Manual, Chapter 1, “Inpatient Hospital Services”, P.40;
  - Medicare Benefit Policy Manual, Chapter 15, “Covered Medical and other Health Services, P 110:

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# Local Coverage Determination (LCD): Trigger Point Injections (L35010)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

## Contractor Information

<table>
<thead>
<tr>
<th>Contractor Name</th>
<th>Contract Type</th>
<th>Contract Number</th>
<th>Jurisdiction</th>
<th>State(s)</th>
</tr>
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<tbody>
<tr>
<td>Novitas Solutions, Inc</td>
<td>A and B MAC</td>
<td>04111 - MAC A</td>
<td>J - H</td>
<td>Colorado</td>
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<td>Novitas Solutions, Inc</td>
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<td>04112 - MAC B</td>
<td>J - H</td>
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# LOCAL COVERAGE DETERMINATION - TPIs

## LCD Information

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<tr>
<th>Document Information</th>
<th>Original Effective Date</th>
<th>Revision Effective Date</th>
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<tbody>
<tr>
<td>LCD ID L35010</td>
<td>For services performed on or after 10/01/2015</td>
<td>For services performed on or after 01/01/2016</td>
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<tr>
<td>Original LCD-9 LCD ID</td>
<td>02/548</td>
<td></td>
</tr>
</tbody>
</table>

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COVERAGE GUIDANCE - TPIs

Coverage Guidance
Coverage Indications, Limitations, and/or Medical Necessity

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by this entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

Trigger point injection is one of many modalities utilized in the management of chronic pain. Myofascial trigger points are self-sustaining hyperirritative foci that may occur in any skeletal muscle in response to strain produced by acute or chronic overload. These trigger points produce a referred pain pattern characteristic for that individual muscle. Each pattern becomes part of a single muscle myofascial pain syndrome (MPS) and each of these single muscle syndromes is responsive to appropriate treatment, which includes injection therapy. Injection is achieved with needle insertion and the administration of agents, such as local anesthetics, steroids and/or local inflammatory drugs.

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THE “MAGIC WORDS” FOR DOCUMENTATION

The diagnosis of trigger points requires a detailed history and thorough physical examination. The following clinical symptoms may be present when making the diagnosis:

- History of onset of the painful condition and its presumed cause (e.g., injury or sprain)
- Distribution pattern of pain consistent with the referral pattern of trigger points
- Range of motion restriction
- Muscular deconditioning in the affected area
- Focal tenderness of a trigger point
- Palpable taut band of muscle in which trigger point is located
- Local taut response to snapping palpation
- Reproduction of referred pain pattern upon stimulation of trigger point

The goal is to treat the cause of the pain and not just the symptom of pain.

Indications

After myofascial pain syndrome (MPS) is established, trigger point injection may be indicated when noninvasive medical management is unsuccessful (e.g., analgesics, passive physical therapy, ultrasound, range of motion and active exercises); as a bridging therapy to relieve pain while other treatments are also initiated, such as medication or physical therapy; or as a single therapeutic maneuver. The logic behind such therapeutic decision making should be obvious in the medical record and available upon Contractor request. Additionally, trigger point injection is indicated when joint movement is mechanically blocked as is the case of the coccygeus muscle.

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Limitations

Acupuncture is not a covered service, even if provided for the treatment of an established trigger point. Use of acupuncture needles and/or the passage of electrical current through these needles is not covered (whether an acupuncturist or other provider renders the service).

Medicare does not cover Prolotherapy. Its billing under the trigger point injection code is a misrepresentation of the actual service rendered.

Only one code from 20552 or 20553 should be reported on any particular day, no matter how many sites or regions are injected.

When a given site is injected, it will be considered one injection service, regardless of the number of injections administered.

As published in CMS IOM 100-06, Section 13.5.1, in order to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary under Section 1862(a)(1)(A). Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 that meet the requirements of the Clinical Trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient’s condition or to improve the function of a malformed body member.
  - Furnished in a setting appropriate to the patient’s medical needs and condition.
  - Ordered and furnished by qualified personnel.
  - One that meets, but does not exceed, the patient’s medical needs.
  - At least as beneficial as an existing and available medically appropriate alternative.

Note: Italicized and/or quoted material is excerpted from the American Medical Association, Current Procedural Terminology (CPT) codes.

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph: NOTE: M0076 is NON-Covered by Medicare

Group 1 Codes:
20552 Inj trigger point 1/2 muscl
20553 Inject trigger points 3>/
M0076 Prolotherapy

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph: It is the provider’s responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

Covered for 20552 and 20553:

Group 1 Codes:

<table>
<thead>
<tr>
<th>ICD-10 Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M53.62</td>
<td>Other specified dermatoses, cervical region</td>
</tr>
<tr>
<td>M54.2</td>
<td>Cervicalgia</td>
</tr>
<tr>
<td>M54.5</td>
<td>Low back pain</td>
</tr>
<tr>
<td>M54.6</td>
<td>Pain in thoracic spine</td>
</tr>
</tbody>
</table>

NOTE: ONLY A PORTION OF THE CODING INFORMATION BEING SHOWN IN SLIDE.
AN EXCERPT FROM GENERAL INFORMATION GIVEN IN LCD

General Information

Associated Information

Documentation Requirements

1. All documentation must be maintained in the patient’s medical record and available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The record must include the physician or non-physician practitioner responsible for and providing the care of the patient.
3. The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.

EXCERPT FROM UTILIZATION GUIDELINES IN LCD
(SEE SITE FOR REFERENCES USED IN LCD)

Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

It is expected that trigger point injections would not usually be performed more often than three sessions in a three month period. If trigger point injections are performed more than three sessions in a three month period, the reason for repeated performance and the substances injected should be evident in the medical record and available to the Contractor upon request.

This contractor may request records when it is apparent that patients are requiring a significant number of injections to manage their pain.

Documentation in the medical record must support the medical necessity and frequency of the trigger point injection(s).

Sources of Information and Basis for Decision
Contractor is not responsible for the continued viability of websites listed.
CHANGES TO NCDs/LCDs?

- It can be done by:
  - Providers; and
  - Beneficiaries

- How? Submit request for new/revised LCDs to your local MAC carrier for a clarification of a section, additions or deletions to acceptable diagnosis codes that support medical necessity and/or changes in indications, limitations, coverage.
  - Request:
    - Must be in writing
    - Must be supported by medical evidence usually in the form of peer reviewed medical literature or other published studies.
  - It could very well be worth the time and work involved in getting changes made for your particular services.

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12.3 - The Comprehensive Error Rate Testing (CERT) Program
(Rev. 560, Issued: 12-12-14, Effective: 01-01-15, Implementation: 01-01-15)

- The Comprehensive Error Rate Testing (CERT) program produces a national Medicare Fee-for-Service (FFS) improper payment rate that is compliant with the Improper Payments Information Act (IPIA) of 2002, most recently amended by the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012.
  - To meet this objective, the CERT review contractor evaluates a random sample of Medicare FFS claims to determine if they were paid properly under Medicare coverage, coding, and billing rules. If these criteria are not met, the claim is counted as either a total or a partial improper payment, depending on the category of error at issue.
The CERT program considers any claim that was paid when it should have been denied or that should have been paid at another amount (including both overpayments and underpayments) to be an improper payment.

The findings can be projected to the entire universe of Medicare FFS claims because the CERT program ensures a statistically valid random sample. Therefore, the improper payment rate calculated from this sample is considered to be reflective of all of the paid claims in the Medicare FFS program during the year.

### Medical Review Part B has the following service specific edits in effect for Jurisdiction H.

<table>
<thead>
<tr>
<th>Edit Number</th>
<th>Service Type</th>
<th>Providers Specialties Impacted</th>
<th>Current Procedural Terminology (CPT)/Description</th>
<th>Documentation Required for Successful Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>378D</td>
<td>Evaluation and Management</td>
<td>11—Internal Medicine, 20—Pulmonary Diseases, 03—Emergency Medicine</td>
<td>99201—Critical care: evaluation and management of the critically ill or critically injured patient, first 30-74 minutes</td>
<td>Critical care visit to support a reasonable and necessary critical care visit. Laboratory, radiology and procedure orders and results. Clearly identify critical care time spent with patient.</td>
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<td>376D</td>
<td>Evaluation and Management</td>
<td>09—Family Practice, 11—Internal Medicine, 29—Pulmonary Diseases</td>
<td>99233—Subsequent hospital inpatient care, typically 30 minutes per day</td>
<td>Subsequent hospital progress note. Lab, radiology and procedure orders and results. Physician orders/follow up. Documentation of total time spent on counseling and coordination of care if billing based on time. E&amp;M service must contain documentation of 2 of 3 components, (Revised history, detailed exam and/or high complexity of medical decision making)</td>
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<tr>
<td>351D</td>
<td>Evaluation and Management</td>
<td>All provider specialties</td>
<td>99208—new patient office or other outpatient visit typically 60 minutes</td>
<td>Initial office history &amp; physical Lab, radiology and procedure orders and results. Physician orders/follow up. Documentation of total time spent on counseling and coordination of care if billing based on time. E&amp;M service must contain documentation of 3 of 3 components, (Revised history, comprehensive exam and/or moderate complexity of medical decision making)</td>
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<tr>
<td>303D</td>
<td>Evaluation and Management</td>
<td>08—Family Practice, 11—Internal Medicine</td>
<td>95555—Initial nursing facility visit, typically 30 minutes per day</td>
<td>Initial nursing facility history &amp; physical Lab, radiology and procedure orders and results. Physician orders/follow up. Documentation of total time spent on counseling and coordination of care if billing based on time. E&amp;M service must contain documentation of 2 of 3 components, (Revised history, comprehensive exam and/or moderate complexity of medical decision making)</td>
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<td>300D</td>
<td>Evaluation and Management</td>
<td>08—Family Practice, 10—Cardiology, 11—Internal Medicine, 29—Pulmonary Diseases, 30—Nephrology</td>
<td>99222—Initial hospital inpatient care typically 50 minutes per day</td>
<td>Initial hospital history &amp; physical Lab, radiology and procedure orders and results. Physician orders/follow up. Documentation of total time spent on counseling and coordination of care if billing based on time. E&amp;M service must contain documentation of 3 of 3 components, (Revised history, comprehensive exam and/or moderate complexity of medical decision making)</td>
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<tr>
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<td>Service Description</td>
<td>Explanation</td>
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<td>565D</td>
<td>Diagnostic X-ray</td>
<td>All specialties.</td>
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<td></td>
<td>T40402 - ultrasound guidance for needle placement (e.g., capillary, aspiration, biopsy, localization)</td>
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<tr>
<td></td>
<td>Imaging examination and interpretation</td>
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<tr>
<td></td>
<td>20611 - percutaneous, aspiration or biopsy, major joint or tumor (i.e., costal, intra-articular knee, subcutaneous tumor or sacrum) with percutaneous needle insertion and recording</td>
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<td>Documentation of medical necessity for use of ultrasound guidance (i.e., description of anatomy of lesion, joint, body area prior to attempt made without use of ultrasound - documentation of BMI ~ 40)</td>
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<td>598D</td>
<td>Medical Care</td>
<td>All specialties.</td>
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<td>J93655 - injection, Transcutaneous, to nail</td>
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<td></td>
<td>Documentation to support medical necessity of injection (i.e., Documentation of lab results confirming HER2 diagnosis)</td>
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<td>Documentation of patient's weight, dosage, administration site, administration route and dosages</td>
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<td>401D</td>
<td>Anesthesia</td>
<td>65—Anesthesiaology</td>
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<td>49—Certified Nurse Anesthetist, Anesthesiologist, Anesthesia Assistant</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>00810 - anesthesia for lower intestinal endoscopic procedures, endoscopy, introduced distal to duodenum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Documentation to support medical necessity of anesthesia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clear and precise documentation of start and stop time of anesthesia service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>140A</td>
<td>Ambulance</td>
<td>Ambulance Service Supplier</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A04086 - ground mileage, per status mile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A04225—ambulance service, advanced life support, non-emergency transport, level 1 (40, 5, 1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A04220—ambulance service, basic life support, non-emergency transport, (40, 5, 1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ambulance trip/transport sheets that include:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>An objective description of the patient’s physical condition functional status that meets Medicare limitation coverage for ambulance services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>History and clinical assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Documentation of supplies/procedures provided (if any)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Resources:

- Tips for Successful Medical Review
- Archived Service Wide Edits

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NATIONAL CORRECT CODING INITIATIVE (NCCI)

CMS developed NCCI edits to:
- Promote national correct coding methodologies; and
- Control improper coding leading to inappropriate payment in Part B claims.

NCCI based on:
- Coding conventions defined by the American Medical Association’s CPT Manual;
- National and local policies and edits;
- Coding guidelines developed by national societies;
- Analysis of standard medical and surgical practices; and
- A review of current coding practices.
NATIONAL CORRECT CODING INITIATIVE EDITS

• CMS annually updates the NCCI Coding Policy Manual for Medicare Services (Coding Policy Manual).
  - The Coding Policy Manual should be utilized by carriers and FIs as a general reference tool that explains the rationale for NCCI edits.
  - Carriers implemented NCCI Procedure-to-Procedure (PTP) edits within their claim processing systems for dates of service on or after 01/01/1996 and began implementing Medically Unlikely (MUE) edits on 01/01/2007.

• Purpose of the PTP edits is to prevent improper payment when incorrect code combinations are reported.

• Inquiries about NCCI program: NCCIPTPMUE@cms.hhs.gov.
How to Locate the NCCI Tables and Manual

The PTP code pair edits, MUE tables, and NCCI manual are accessed through the National Correct Coding Initiative Edits webpage at [www.cms.gov/Medicare/Coding/NationalCorrectCoding/Edits]. Click on the CMS website.

Links to the PTP Coding Edits and Medically Unlikely Edits webpages are provided in the menu on the top left side of the National Correct Coding Initiative Edits webpage. Scroll to the Downloads section at the bottom of the National Correct Coding Initiative Edits webpage to find a link to the NCCI manual.

Background: NCCI Edits

The NCCI is comprised of two provider-type choices of PTP code pair edits and three provider-type choices of MUEs:

### PTP Code Pair Edits

1. **PTP Edits-Practitioners**
   
   These PTP code pair edits are applied to claims submitted by physicians, non-physician practitioners, and Ambulatory Surgery Centers (ASCs).

2. **PTP Edits-Hospitals**
   
   This set of PTP code pair edits is applied to the following Types of Bills (TOBs): subject to the Outpatient Code Editor (OCE): Hospitals (TOB 12X and 13X), Skilled Nursing Facilities (SNFs) (TOB 22X and 23X), Home Health Agencies (HHAs) Part A (TOB 24X), Outpatient Physical Therapy and Speech-Language Pathology Providers (OPTs) (TOB 74X), and Comprehensive Outpatient Rehabilitation Facilities (CORFs) (TOB 75X).

### MUEs

1. **Practitioner MUEs**
   
   All physician and other practitioner claims are subject to these edits.

2. **Durable Medical Equipment (DME)**
   
   Supplier MUEs: These edits are applied to claims submitted to DME MACs. At this time, this file will include HCPCS A-B and E-V codes in addition to HCPCS codes under the DME MAC jurisdiction.

3. **Facility Outpatient MUEs**
   
   Claims for TOB 13X, 14X, and Critical Access Hospitals (CAHs) are subject to these edits.

### When is a code the reimbursable code of a PTP code pair?

To determine whether our example code 99015 is the reimbursable code of a PTP code pair, we open the Practitioner PTP Edits Table 2 and search for 99015 in Column 1. (We can use the Microsoft Excel Find Tool to easily search for all instances of 99015 in Column 1. In the Filter the PTP Data Tables section at the end of this booklet provides instructions for using the Filter tool in Microsoft Excel).

Figure 2 shows part of the Practitioner PTP Edits Table 2, with our example code 99015 in Column 1.

**Information: Claims submitted by practitioners are subject to PTP code pair edits, which are applied to claims submitted by physicians, non-physician practitioners, and Ambulatory Surgery Centers (ASCs). The NCCI is comprised of two provider-type choices of PTP code pair edits and three provider-type choices of MUEs.**

---

**Table 2: PTP Code Pair Edits**

| Column 1 | Column 2 | Code | Description | External Date | Effective Date | Modifier | PTP Code Pair | Edits
|----------|----------|------|-------------|---------------|---------------|---------|---------------|-------
| 99015    | 99015    | 99015| Inpatient  | 01/06/1996    | 01/06/2009    | 99015   | 99015         | 99015 |
| 99016    | 99016    | 99016| Outpatient | 01/06/1996    | 01/06/2009    | 99016   | 99016         | 99016 |

**Notes:**

- **Inpatient:** Claims submitted by practitioners are subject to PTP code pair edits, which are applied to claims submitted by physicians, non-physician practitioners, and Ambulatory Surgery Centers (ASCs).

- **Outpatient:** Claims submitted by practitioners are subject to PTP code pair edits, which are applied to claims submitted by physicians, non-physician practitioners, and Ambulatory Surgery Centers (ASCs).

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**Figure 2: Table 2**

- **Column 1:** Indicates the payable code.
- **Column 3:** Indicates the code that is not payable with this particular Column 1 code, unless a modifier is permitted and submitted.
MODIFIER INDICATORS

How do you know when an appropriate modifier may be used?

Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass a PTP code pair edit if the clinical circumstances do not justify its use. If the Medicare Program imposes restrictions on the use of a modifier, the modifier may only be used to bypass a PTP code pair edit if the Medicare restrictions are fulfilled.

In the modifier indicator column, the indicator 0, 1, or 9 shows whether an PTP-associated modifier allows the PTP code pair to bypass the edit. The following Modifier Indicator Table provides a definition of each of these indicators.

<table>
<thead>
<tr>
<th>MODIFIER INDICATOR</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 (Not Allowed)</td>
<td>There are no modifiers associated with NCCI that are allowed to be used with this PTP code pair; there are no circumstances in which both procedures of the PTP code pair should be paid for the same beneficiary on the same day by the same provider.</td>
</tr>
<tr>
<td>1 (Allowed)</td>
<td>The modifiers associated with NCCI are allowed with this PTP code pair when appropriate.</td>
</tr>
<tr>
<td>9 (Not Applicable)</td>
<td>This indicator means that an NCCI edit does not apply to this PTP code pair. The edit for this PTP code pair was deleted retroactively.</td>
</tr>
</tbody>
</table>

Hospital PTP edits: These PTP code pair tables operate the same as the practitioner PTP code pair tables; however, modifiers and coding pairs may differ from the practitioner PTP code pair tables because of differences between facility and professional services.

Now that you’ve learned how to use the PTP code pair tables, let’s learn how to search for MUEs.

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GENERAL CODING PRINCIPLES

• Per NCCI manual, Chapter 1:
  – Physicians must report services correctly.
  – This manual discusses general coding principles in Chapter 1 and principles more relevant to other specific groups of HCPCS/CPT codes in other chapters. There are certain types of improper coding that physicians must avoid.
    • Physicians must avoid downcoding.
    • Physicians must avoid upcoding.
    • Physicians must report units of service correctly.

Coding is Based on Standards of Medical/Surgical Practices.
PRIVATE CARRIER’S COVERAGE POLICIES

AETNA – CLINICAL POLICY BULLETINS

• Using Clinical Policy Bulletins to determine medical coverage:
  – Medical Clinical Policy Bulletins (CPBs) detail the services and procedures we consider medically necessary, cosmetic, or experimental and unproven. They help us decide what we will and will not cover. CPBs are based on:
    • Peer-reviewed, published medical journals
    • A review of available studies on a particular topic
    • Evidence-based consensus statements
• Expert opinions of health care professionals
• Guidelines from nationally recognized health care organizations
• Search our Medical Clinical Policy Bulletins
• Enter your keyword or 4-digit CPB number (for example, enter 0059 to find CPB 59) to find related Medical Clinical Policy Bulletins.

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AETNA – INFLUENZA VACCINE

- **Policy:** Aetna considers standard or preservative-free injectable influenza vaccine a medically necessary preventive service for members when influenza immunization is recommended by the member's doctor.
  - Aetna considers high-dose injectable influenza vaccine (**Fluzone High-Dose**) a medically necessary preventive service for members age 65 years of age or older when influenza immunization is recommended by the member's doctor.

- Aetna considers intradermal influenza vaccine experimental and investigational for all other indications because its effectiveness for indications other than the one listed above has not been established.

- Aetna considers intranasally administered influenza vaccine experimental and investigational. The Centers for Control and Prevention Advisory Committee on Immunization Practices recommends against use of intranasally administered influenza vaccine during the 2016-2017 influenza season.

- **See also** [CPB 0476 - Influenza Rapid Diagnostic Tests](#).

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CIGNA – MEDICAL NECESSITY DEFINITIONS

• MEDICAL NECESSITY DEFINITIONS

• Cigna HealthCare Definition of Medical Necessity for Physicians:
  – "Medically Necessary" or "Medical Necessity" shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
  • in accordance with the generally accepted standards of medical practice;
  • clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
  • not primarily for the convenience of the patient or Physician, or other Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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• For these purposes, "generally accepted standards of medical practice" means:
  – standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community;
  – Physician Specialty Society recommendations;
  – the views of Physicians practicing in the relevant clinical area; and
  – any other relevant factors.

• Preventive care may be Medically Necessary but coverage for Medically Necessary preventive care is governed by terms of the applicable Plan Documents.

• (Note: This is an excerpt only from the full document concerning medical necessity)
CLINICAL, REIMBURSEMENT, AND ADMINISTRATIVE POLICY UPDATES

To support access to quality, cost-effective care for our patients with a medical care management company, CareAllies is offering select clinical, reimbursement, and administrative policy updates, as well as our medical coverage policies and provider network information.

All new medical benefit and modified medical policies are now available to all clients operating those for their patients with Cigna’s CareAllies platform. Additional information, including updates of monthly coverage policy changes and all Major Medical Code changes, is available by logging into Cigna’s CareAllies website (www.cigna.com/careallies).

If you are not registered for CareAllies, please contact your Cigna representative for assistance.

### Table of Policy Updates

<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Updates</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dress Testing (DID)</td>
<td>Contact your current coverage policy to allow dermatology units per day for sale. Healthcare Common Procedure Coding System (HCPCS) code D8053 will be added to the claim when HCPCS code D8052 or D8051 is being entered.</td>
<td>July 20, 2016</td>
</tr>
<tr>
<td>Shopping and Handling (SOD)</td>
<td>The current diagnostic test fee for shopping and handling coverage pricing will be increased to exclude all additional codes.</td>
<td>July 5, 2016</td>
</tr>
<tr>
<td>Physical Therapy (PT7)</td>
<td>A medically necessary physical therapy service will be applied to the screening of therapeutic physical therapy (CPT) codes 97143, 97144, 97145, 97146, 97147, 97148, 97149, 97150, and 97526.</td>
<td>August 5, 2016</td>
</tr>
<tr>
<td>Baseline Blood Work (BBL)</td>
<td>Prophylactic blood work will be required for CPT codes 99000, 99001, and 99002.</td>
<td>August 26, 2016</td>
</tr>
<tr>
<td>Pharmacy and Kit Services (KTR)</td>
<td>When a sterile drug kit (CPT) is billed, the kit material will be recharged on the claim in order for waste to be reimbursed.</td>
<td>October 1, 2016</td>
</tr>
<tr>
<td>Guidewell - Ambulance/Facility Revenue Services Support and Equipment Reimbursement Policy (FRE)</td>
<td>Consent via our reimbursement policy, all cardiology and essential care services will only be billed globally, but not to exceed the amount billed.</td>
<td>October 10, 2016</td>
</tr>
<tr>
<td>Clinical Vitality: Comprehensive Reimbursement Policy (CVR)</td>
<td>A limited set of predetermined services utilized by CPT codes 99005 and 99012, and when above a procedure is to be performed. For operational reports that be reviewed before reimbursement to determine if the reprocessor situation is met. If not met, the claim will be denied.</td>
<td>October 10, 2016</td>
</tr>
</tbody>
</table>

*Available for all new coverage policies with Cigna.

---

INTRODUCING THE NEW CAREALLIES

Custom solutions to support the transition to value-based care

The health care industry is on an accelerated course to transition to a model that focuses on value instead of volume, with an emphasis on quality of care and improved outcomes for patients. This is changing health care payment models and creating current business models to implement and be successful in the new market.

Facing this challenge, we developed CareAllies to provide a value-based solution to meet the complex and wide-ranging needs of health care providers.

CareAllies can help:

- In June 2016, we launched new CareAllies services.
- CareAllies aims to provide technology, consulting, and management solutions to support health care provider transformation to a value-based care model across all payers. CareAllies solutions help deliver better quality and financial outcomes using a combination of specialist and administrative services to improve patient outcomes.
- CareAllies solutions are built on the fundamentals necessary for a successful transition, including:
  - Experience-based services that inform and optimize health care professionals throughout value-based care models.
  - Technology to integrate health care professionals in a value-based care setting.
  - Data analytics and reporting to inform decision-making and deliver services.
  - Advanced analytics and technology to enable a population health solution across payer types.

**Additional Information**

CareAllies is a wholly-owned subsidiary of Cigna, providing services designed for a multi-payer environment for all clients and all coverage types.

Visit the CareAllies website at <www.careallies.com> to learn more about their services and solutions.
UnitedHealthcare

Evaluation and Management (E/M) Reimbursement Policy

Evaluation and Management (E/M) Reimbursement Policy

Policy Number: 2016R5007A
Annual Approval Date: 4/21/2016
Approved By: Payment Policy Oversight Committee

Reimbursement Guidelines

All E/M Services

When assigning an E/M Level of Service for a patient Encounter, significant factors to consider are the nature of the presenting problem (NePP) and the complexity of medical decision making (MDM).

The expectation of documentation necessary to substantiate the claim as billed will follow the general principles of medical record documentation which apply to all types of medical and surgical services in all settings. While E/M services vary in several ways, such as the nature and amount of physician work required, the following general principles help ensure that medical record documentation for all E/M services is appropriate:

- The medical record should be complete and legible;
- The documentation of each patient Encounter should include but not be limited to:
  - Reason for the Encounter and relevant history, physical examination findings, and prior diagnostic test results;
  - Assessment, clinical impression, or diagnosis;

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UHC – NEW E/M GUIDELINES

- Medical plan of care;
- Date and legible identity of the observer;
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;
- Past and present diagnoses should be accessible to the treating and/or consulting physician;
- Appropriate health risk factors should be identified;
- The patient’s progress, response to and changes in treatment, and revision of diagnosis should be documented;
- The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by documentation in the medical record;
- Review of past medical records must include a summary of relevant information gleaned from this review in order to receive credit in the Amount and Complexity of Data section.

While there is no prohibition on the use of proprietary templates, documentation from either an electronic health record (EHR) or hard-copy that appears to be cloned (selected information from one source and replicated in another location by copy/paste methods) from another record, including but not limited to history of present illness (HPI), exam, and MDM, would not be acceptable documentation to support the claim as billed.

For example, HPI should be the provider's individual description of the development of the patient’s present illness from the first sign and/or symptom, or from the previous Encounter to the present; the exam should be the individual description of the patient’s exam at the time of the Encounter and MDM should also be individualized to the Encounter for the patient to outline a specific assessment and plan of care.

Medical record documentation should be provided upon request.

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UHC – NEW- E/M IN ER/ED

E/M Services Performed in an Emergency Department (ER/ED) Place of Service

CPT codes 99281-99285 are used to report E/M services rendered in an ER/ED place of service. Evaluating for level of care appropriateness for these codes in an ER/ED place of service includes a review of the tests and management options that are available to be performed during the initial visit.

The 1995 CMS Documentation Guidelines state that the number of diagnoses and management options that must be considered “...is based on the number and types of problems addressed during the Encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.” Additional Work-up Planned is an element of review which includes a number of diagnoses and management options. The Additional Work-up Planned element contributes to indicating the complexity of a patient based on the clinician’s utilization of diagnostic tests. Unitedhealthcare utilizes the industry standard guidelines to determine the appropriate level of care is as follows:

<table>
<thead>
<tr>
<th>A. Number of Diagnoses and Management Options</th>
<th>Points Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor problems (stable, improved or worsening) Max of 2 points can be given</td>
<td>1</td>
</tr>
<tr>
<td>Established Problem – stable improved</td>
<td>1</td>
</tr>
<tr>
<td>Established Problem – Worsening</td>
<td>2</td>
</tr>
<tr>
<td>New Problem – No Additional Work-up Planned. Max of 1 point can be given</td>
<td>3</td>
</tr>
<tr>
<td>New Problem – Additional Work-up planned</td>
<td>4</td>
</tr>
</tbody>
</table>

A provider receives 3 points for “New Problem, No Additional Work-up Planned,” and 4 points for “New Problem, Additional Work-up Planned.” This one-point difference can affect whether a level 4 or level 5 code is appropriate. Please note that all Encounters with ED patients are considered “New Problem.”

Encounters for purposes of scoring.

An example of Additional Work-up Planned, is if the physician schedules testing him/herself or communicates directly with the patient’s primary physician or representative the need for testing which is to be done after discharge from the ED, and the appropriate documentation has been recorded. Credit for “Additional Work-up Planned” is granted (4 points assigned). Credit is not given for the work-up if it occurs during the ER Encounter. This interpretation is consistent with the level 5 code description that “…usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function…” Patients admitted to the hospital under the care of a physician other than the ER physician may have testing done as part of the admitting physician’s care for that patient. The ER physician will not receive credit for the Additional Work-up Planned done under the care of the admitting physician.

Definitions

Additional Work-up Planned: Any testing/consultation/referral that is being done beyond that Encounter to assist the provider in medical decision making.

Encounter: Interaction between a covered member and a healthcare provider for which evaluation and management services or other service(s) are rendered and results in a claim submission.

Questions and Answers

1. When a separate written report for diagnostic tests/studies is prepared by the same individual performing the E/M service, should this be considered as a factor in the E/M code selection?
   A: No. Any specific identifiable procedure reported separately from the E/M service should not be considered in the selection of E/M service level reported.

2. Unitedhealthcare require medical records for all reported E/M services?
   A: No. There may be occasions where Unitedhealthcare could request medical records to determine the appropriate level of E/M service has been reported.

Attachments: Please right-click on the icon to open the file.

Evaluation and Management Procedure Codes

Resources

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**Multiple Procedure Policy**

**Policy Number**: 2016R0034E

**Annual Approval Date**: 7/8/2016

**Approved By**: 

**Payment Policy Oversight Committee**: 

**UnitedHealthcare**

A UnitedHealth Group Company

**REIMBURSEMENT POLICY**

**CMS-1500**

**Multiple Procedure Ranking**

UnitedHealthcare uses the CMS Facility Total RVUs to determine the ranking of primary, secondary and subsequent procedures when those services are performed in a facility setting (Place of Service [POS] 19, 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56 and 61). Procedures performed in a place of service other than the facility POS setting will be ranked by the CMS Non-Facility RVUs.

Examples:

Note: RVU values in these examples may not accurately reflect the current NPIFS and are intended for illustrative purposes only.

<table>
<thead>
<tr>
<th>POS 11 (Office)</th>
<th>Code</th>
<th>Description</th>
<th>Units</th>
<th>Non-Facility Total RVUs</th>
<th>Facility Total RVUs</th>
<th>Multiple Procedure Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>11012</td>
<td>1</td>
<td>Debride skin/muscle/bone, fx</td>
<td>1</td>
<td>18.59</td>
<td>11.50</td>
<td>1 - Primary</td>
</tr>
<tr>
<td>14301</td>
<td>1</td>
<td>Adjacent skin tissue rearrangement</td>
<td>1</td>
<td>18.56</td>
<td>16.16</td>
<td>2 - Secondary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POS 22 (Outpatient Hospital)</th>
<th>Code</th>
<th>Description</th>
<th>Units</th>
<th>Non-Facility Total RVUs</th>
<th>Facility Total RVUs</th>
<th>Multiple Procedure Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>11012</td>
<td>1</td>
<td>Debride skin/muscle/bone, fx</td>
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<td>16.16</td>
<td>1 - Primary</td>
</tr>
</tbody>
</table>

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**HOW TO OVERCOME THE CHALLENGES**

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NAVIGATING THROUGH THE OBSTACLES FOR SUCCESS

PATH 4
Educate! Train! Establish Denial Tracking Analyses!

PATH 3
Understand edits and rationale for your specific NCCI edits.

PATH 2
Download pertinent Medicare NCDs and LCDs
Information Critical - the "Magic Words" for Documentation

PATH 1
START YOUR ENGINES - ORGANIZE!
Prepare Managed Care Catalog of Coverage Policies with Specific Definition of "Medical Necessity".
Source: PowerPoint Charts & Graphics.CEOs Bundle

QUESTIONS?

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Questions?

• Thank you for your attendance!

• Get your questions answered on PMI's Discussion Forum: http://www.pmimd.com/pmiForums/rules.asp

• Contact information: mcollins@pmimd.com