Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1057

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4822 (Cont.) - 4822 (Cont.)	4-557- 4-558 (2 pp.)	4-557- 4-558 (2 pp.)

CHANGED PROCEDURES--*EFFECTIVE DATE*: January 1, 1995
***IMPLEMENTATION DATE*: July 1, 2000**

Section 4822, Billing Requirement for Global Surgeries, is revised to make the language of this section consistent with the current wording of §15350.B, Inpatient Dialysis on Same Date as Evaluation and Management. The requirement to conduct reviews of claims for services for CPT codes 99221 through 99223, 99251 through 99255 and 99238 that are furnished on the same date as inpatient dialysis is deleted. These codes are separately payable using modifier " -25". CPT code 99239 is also added to the list of codes that need not be reviewed.

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These instructions should be implemented within your current operating budget.

visits. See §§4822.A.9 and 4824.A for instances where modifier "-24" may be used for inpatient hospital visits (including critical care).

8. Significant Evaluation and Management on the Day of a Procedure. The following modifier was established to facilitate billing of evaluation and management services on the day of a procedure for which separate payment may be made.

"-25": Significant, separately identifiable evaluation and management service by same physician on the day of a procedure: The physician may need to indicate that on the day a procedure or service that is identified with a CPT-4 code was performed, the patient's condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed. This circumstance may be reported by adding the modifier "-25" to the appropriate level of evaluation and management service.

Claims containing evaluation and management codes with modifier "-25" are not subject to prepayment review except in the following situations:

- When preoperative critical care codes are being billed for within a global surgical period (see §§4822.A.9 and 4824.A); and

- When you have conducted a specific medical review process and determined, after reviewing the data, that an individual or group have high statistics in terms of the use of modifier "-25," have done a case-by-case review of the records to verify that the use of modifier "-25" was inappropriate, and have educated the individual or group as to the proper use of this modifier.

Effective January 1, 1995 all evaluation and management services provided on the same day as inpatient dialysis service should be denied with the exception of CPT codes 99221-99223, 99251-99255, 99238 and 99239. These codes are separately payable using modifier “-25".

9. Critical Care.--Critical care services provided during a global surgical period for a seriously injured or burned patient are not considered related to a surgical procedure and may be paid separately under the following circumstances.

Preoperative and postoperative critical care may be paid in addition to a global fee if:

- The patient is critically ill and requires the constant attendance of the physician; and

- The critical care is above and beyond, and, in most instances, unrelated to the specific anatomic injury or general surgical procedure performed.

Such patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

In order for these services to be paid, two reporting requirements must be met:

o Codes 99291/99292 and modifier "-25" (for preoperative care) or "-24" (for postoperative care) must be used; and

o 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. Request additional documentation if you feel it is needed to process the claim.

10. Unusual Circumstances.--Surgeries for which services performed are significantly greater than usually required may be billed with the "-22" modifier added to the CPT-4 code for the procedure. Surgeries for which services performed are significantly less than usually required may be billed with the "-52" modifier. Instruct billers to provide:

o A concise statement about how the service differs from the usual; and

o An operative report with the claim.

Modifier "-22" should only be reported with procedure codes that have a global period of 0, 10, or 90 days. There is no such restriction on the use of modifier "-52."

B. Date(s) of Service.--Physicians who bill for the entire global surgical package, or for only a portion of the care, must enter the date on which the surgical procedure was performed in the "From/To" date of service field. This will enable you to relate all appropriate billings to the correct surgery. Instruct physicians who share postoperative management with another physician to submit additional information showing when they assumed and relinquished responsibility for the postoperative care. If the physician who performed the surgery relinquishes care at the time of discharge, he or she need only show the date of surgery when billing with modifier "-54."

However, if the surgeon also cares for the patient for some period following discharge, instruct the surgeon to show the date of surgery and the date on which postoperative care was relinquished to another physician. Instruct the physician providing the remaining postoperative care to show the date care was assumed. This information should be shown in Item 19 on the paper Form HCFA 1500 and in the narrative portion of the HA0 record on the National Standard Format for electronic claims.

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. (See §§3350 and 3350.3.) The following are guidelines for the appropriate billing procedures:

o If the entire global package is provided in a HPSA, physicians should