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Multiple Surgery Reduction Errors:
Single Line Modifier 51
Underpayments

Investigating Agencies:
Connolly Consulting Associates, Inc., Recovery Audit Contractor—Region C
HealthDataInsights, Recovery Audit Contractor—Region D

Source Documents:
CMS IOM Pub. 100-04, Chapter 12, §40.6
CMS IOM Pub. 100-04, Chapter 23, §30

Start Dates:
March 31, 2010—Region C
December 17, 2010—Region D

Explanation of Investigation:
Recovery Audit Contractors (RAC) in Regions C and D have approved an issue regarding a multiple reduction error occurring when only one surgical procedure for the same patient on the same date of service is reported as a single line item with modifier 51 appended. In reporting a single line item service with modifier 51 Multiple procedures, the payment is inappropriately reduced by 50 percent and results in an underpayment.

Background:
Multiple surgeries are described as separate procedures performed by a physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be permitted.

Multiple procedures are distinct from services that are components of, or incidental to, a primary procedure. Intraoperative services, incidental surgeries, or components of a more major surgery are not reported separately. Major surgeries are determined based on the approved amount in the Medicare Physician Fee Schedule Data Base (MPFSDB), not on the amount submitted from the providers. A major surgery, as based on the MPFSDB, may or may not be the one with the larger submitted amount. An indicator in field 21 of the MPFSDB indicates whether the standard payment policy rules apply to a multiple surgery or whether special payment rules apply.

When billing for multiple surgeries by the same physician on the same date of service, report the more major surgical procedure first without a modifier. Additional surgical services performed should be appended with modifier 51. Reporting a single surgical service and erroneously appending modifier 51 results in an underpayment by applying a 50 percent reduction.

Investigative Findings:
N/A

Strategies for Risk Prevention:
Develop and implement policies for staff members that include a clear explanation of the appropriate use of modifier 51. This can and should include referencing Medicare guidance on multiple surgeries. Familiarize staff with the Medicare Physician Fee Schedule Data Base and multiple procedure indicators. Education and instruction around modifier usage should be ongoing for all staff and providers with particular attention paid to new employees.
Training for staff should include completion of the CMS-1500 form and sequencing surgical services according to RVU and assignment of modifiers as applicable.

Coverage
Staff should be aware of quarterly and annual changes to the Medicare physician fee schedule and database. New transmittals should be periodically reviewed to ensure that any changes or guidance as pertains to the multiple surgery payment rules and modifier 51 are noted and implemented.

Coding Guidelines
Review all surgery claims for proper sequencing and modifier usage. Verify that claims with more than one procedure have been listed in order of the highest RVU to the lowest RVU. Pay particular attention to claims with single line item services and ensure that if a modifier has been appended to a single line item, that it is appropriately reported. Do not permit submission of claims with modifier 51 appended to a single line item surgical procedure.

Modifier Guidelines
Modifier 51 should never be reported with a single line item surgical service. Reporting modifier 51 in such a situation will result in an underpayment. Modifier 51 should also not be appended to the first line item major service when more than one surgery is being reported; rather, it should be reported on the lesser and subsequent procedures.

Billing Guidelines
Report the primary surgical service as the one with the highest RVU associated with it as the first line item. Subsequent services with the next highest RVU should be reported next continuing down to the lowest valued service being the last line item. Append modifier 51 to all subsequent services. Avoid the use of modifier 51 on the primary or first listed service and on single line item services. In situations where two or more surgeons each perform a distinct and different, unrelated surgery on the same patient on the same day, payment adjustment rules may not be applied. Modifier 51 would not be appropriate to report unless one of the two surgeons individually performed multiple surgeries.

Corrective Actions:
- Identify all services that have been reported with modifier 51.
- Determine if any claims contain single line item surgical procedures.
- If claims have been submitted erroneously and resulted in an underpayment, take steps to contact the payer and submit a corrected claim.
- Ensure proper training and education to avoid future problems related to this issue.

Resources:
CMS IOM Pub. 100-04, Chapter 12, §40.6
CMS IOM Pub. 100-04, Chapter 23, §30
Connolly Consulting Associates, Inc., Recovery Audit Contractor—Region C: CMS Approved Audit Issues
HealthDataInsights, Recovery Audit Contractor—Region D: New Issues approved by CMS

Compliance Policy:
MOD-1.1 Modifiers
MED-1.2: Untimed Codes

Coding Guidance:
According to the CMS Internet Only Manual, Pub. 100-04, chapter 20.2, section B, “When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe (‘untimed’ HCPCS), the provider enters ‘1’ in the field labeled units. For untimed codes, units are reported based on the number of times the procedure is performed, as described in the HCPCS code definition (often once per day).” For example, both CPT code 92506 Speech-language pathology evaluation, and 97001 Physical therapy evaluation, do not include specific timeframes but may require up to or longer than one hour to complete. However, only one unit should be billed regardless of the actual number of minutes spent providing the service.

Billing Guidelines
To properly code and correctly report untimed services, it is important to clearly understand the difference between an untimed and a timed code. When billing timed codes, the correct number of units must be assigned to accurately reflect the total time provided to the patient. Untimed services are never billed with more than one unit.

Careful attention must be paid to reading the code description to determine whether the service has a specified time associated with it. Remember, untimed services do not have a time period specified within the code's definition.

The first step to accurate and correct billing requires a complete understanding, interpretation, and application of payer guidelines. Furthermore, policies can be revised and therefore, retaining current and up-to-date information as pertains to existing billing practices is imperative. Always include any new guidance issued as part of your billing compliance program. One way to successfully do this is to assign a staff member to routinely and regularly check the Medicare administrative contractor (MAC) and recovery audit contractor (RAC) websites for your location to see if any updates have been issued.

Keep in mind that as the RACs perform audits, additional data are generated. The data may reference other types of untimed codes representing services performed in the practice or indicate site of services where the untimed code error most often occurs, the specialties or provider types most likely to incur issues with untimed codes, as well as other key pieces of information. All of this can be very useful as both educational and instructional tools to help with ongoing staff training and compliance.

The practice management system the practice uses may allow assignment of one unit for all untimed codes reported by the providers. If anyone attempted to report more than one unit, the system might require a manager override or a perhaps a caution message would appear on the screen requiring the employee to approve more than one unit. Often this type of automatic reminder can be quite effective.

Documentation
Documenting the amount of time spent with a patient is always considered a good idea. Clearly, this is necessity when reporting time-based services such as critical care. While no one would ever suggest that documenting time is not a good best practice, when it comes to untimed codes, it can create confusion. Therefore, always be sure that providers and staff alike recognize that although time may be documented, only one unit can be reported.

There are a number of codes that represent the number of visits versus the total amount of time spent with the patient.

Local/National Coverage Issues
[Insert Local Coverage Determinations Information Here]

Indications and Limitations of Coverage and/or Medical Necessity
[Insert Local Coverage Determinations Information Here]

ICD-9-CM Codes that Support Medical Necessity
[Insert Local Coverage Determinations Information Here]

Documentation Requirements
[Insert Local Coverage Determinations Information Here]

Official Resources
Connolly Healthcare, RAC Jurisdiction C, Approved Issues Medicare Claims Processing Manual, Pub. 100-04, chapter 5, section 20.2 (b)—Reporting of Service Units with HCPCS: Time and Untimed Codes

Auditing and Monitoring

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Corrective Action (including education) | Forms and Templates

Next Review Due

Auditing Worksheet

| Account/medical record number: ____________________________ | Provider ____________________________ |
| Date of service: _______________________________________ | Date of Bill ____________________________ |
| Reviewer: _____________________________________________ | Date of Review ____________________________ |