Effective for claims with dates of service on and after January 1, 2008, Medicare contractors shall have discretion to establish local coverage policies for those indications not included in NCD 110.21. NHIC has established Local Coverage Determination (LCD) L17753 for ESA administration. This LCD can be found at http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=17753&lcd_version=55&show=all.

Denials of claims for ESAs are based on reasonable and necessary determinations established by NCD 110.21. A provider may have the beneficiary sign an Advanced Beneficiary Notice, making the beneficiary liable for services not deemed reasonable and necessary and thus not covered by Medicare.

For additional information:
CMS Change Request 5699 at http://www.cms.hhs.gov/transmittals/downloads/R1412CP.pdf
CMS Change Request (CR) 5480 at
http://www.cms.hhs.gov/transmittals/downloads/R1212CP.pdf
CMS Pub. 100-04, Chapter 8, section 60.2.3.1
http://www.cms.hhs.gov/manuals/downloads/clm104c08.pdf

EVALUATION AND MANAGEMENT (E/M)

Report the modifiers listed below on E/M codes only.

-21 Prolonged Evaluation and Management Services: When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be reported by adding modifier 21 to the evaluation and management code number. A report is required.

CMS has classified this modifier as "informational only" for which no additional reimbursement is allowed. Although the description indicates a report may be appropriate, **please do not submit any reports**.

-24 Unrelated evaluation and management service by the same physician during the postoperative period

Modifier -24 was intended for use with the E/M service or eye exam codes performed during the postoperative period for a reason(s) unrelated to the original major or minor surgery. It is not to be used for medical management of a patient by the surgeon following surgery.

Billing Tips:

- Use of the -24 modifier is appropriate with CPT codes 99201-99499 and 92012-92014.

- Services submitted with modifier -24 must be sufficiently documented in the medical record to establish that the visit was unrelated to the condition for which the surgery was performed. Do not submit the documentation unless requested to do so.
- Append modifier -24 to the E/M code performed during a pre or postoperative period of a procedure performed by the same physician, but which is unrelated to the major or minor surgical procedure performed.
- When submitting modifier 24 with codes (99291-99292), documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted.

Examples of Supporting Documentation:

- ICD-9-CM code(s) that are **clearly** unrelated to the surgery
- Documentation clearly explaining why the visit is unrelated to the surgery.
- Documentation indicating "immunosuppressive therapy" for organ transplants.

To determine the global period of a surgery, refer to the Medicare Physician Fee Schedule database (MPFSDB). Access the database directly from the CMS Website at http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=2

There is a Global Surgery Period Calculator available on the NHIC website under "Self-Service Tools" that will assist in determining the end of the global period for major surgeries.

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician 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 the documentation that satisfies the relevant criteria for the respective service to be reported. The E/M service may be prompted by the symptom 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. Documentation in the patient's medical record must support the use of this modifier.

Note: **This modifier is not used to report an E/M service that resulted in a decision to perform major surgery (i.e., those with a 90-day follow-up period). See modifier -57.** For significant, separately identifiable non E/M services, see modifier 59.

Example:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
216 8
1. ____ . ____ 3. ____ . ____
2. ____ . ____ 4. ____ . ____

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER
1	09012007			09012007			11		99213	25	1
2	09012007			09012007			11		17000		1
3											

Billing Tips:

No supporting documentation is required with the claim when this modifier is submitted. However, the patient's medical records must contain information to support the use of modifier -25 and be available upon request. The following are the exceptions:

- This modifier should not be submitted with E/M codes that are explicitly for new patients only: 92002, 92004, 99201-99205, 99281-99285, 99321-99323, and 99341-99345. These services are not considered part of the global surgical policy.
- Use modifier -25 on initial hospital visit (99221-99223), an initial inpatient consultation (99251-99255) and a hospital discharge service (99238 and 99239) , when billed for the same date as an inpatient dialysis service.

- Use modifier -25 when preoperative critical care codes (**99291-99292**) are billed within a global surgical period. Reporting these E/M services with modifier -25 indicates that they are significant and separately identifiable. Documentation that the patient is critically ill and requires the constant attention of the physician, and the critical care is unrelated to the specific anatomic injury or general procedure performed must be submitted.
- Use modifier -25 on an E/M service when performed at the same session as a preventive care visit when a significant, separately identifiable and medically necessary E/M service is performed in addition to the preventive care. The E/M must be carried out for a non-preventive clinical reason, and the ICD-9-CM code(s) for the E/M service should clearly indicate the non-preventive nature of the E/M service.
- Use modifier -25 if the decision for surgery is made on the same day as a minor surgery (i.e., those with a 0 or 10- day follow-up period) if the decision is made during an E/M service the day of surgery.
- This modifier may be used to indicate that an E/M service was provided on the same day as another procedure that would normally bundle under National Correct Coding Initiative (NCCI). In this situation, modifier -25 signifies that

the E/M service was performed for a reason unrelated to the other procedure. Access the CMS website for the National Correct Coding Initiative at http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage.

- Do not use modifier -25 on a surgical code (10021-69999) since this modifier is used to explain the special circumstance of providing the E/M service on the same day as a procedure.

NOTE: The most common cause for claim denial of an unrelated E/M service billed on the same day as another procedure or during the post operative period for a non-surgery related reason is due to the omission of modifier -25.

Multiple Modifiers May Apply

- When a visit occurs on the same day as a surgery with "0" global days and within the global period of another surgery AND the visit is unrelated to both surgeries, modifiers 24 and 25 must be submitted. For example: A patient comes to the office for consultation and an endoscopic procedure is performed. The results require immediate performance of major surgery the next day. The consultation would require the use of modifier -24 for the endoscopic procedure, and -25 for the major surgery performed the next day.

-57 Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier -57 to the appropriate level E/M service

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 428 . 0 3. _____ . _____

2. _____ . _____ 4. _____ . _____

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER
1	06012007			06012007			11		99212	57	1
2	06022007			06022007			21		33945		1
3											

Note:
Modifier -57 is only used with evaluation and management services performed within 24 hours of a major procedure. The global period for a major procedure includes the day before, the day of, and the 90 days immediately following the procedure.

Billing Tips:

- E/M services on the day before the procedure, the day of the procedure, and within the 90-day postoperative period are generally not payable. Only initial services and services unrelated to the procedure performed may be considered for payment.
- Do not use Modifier -57 with minor surgeries (zero- to 10 day postoperative period). See Modifier 25.
- No supporting documentation is required with the claim when submitted but must be included in the patient's medical record and available upon request.

For additional information: refer to the "General Surgery Billing Guide" on the NHIC website at **http://www.medicarenhic.com/providers/pubs/surgeryguide.pdf**
CMS Internet Only Manual (IOM) Pub. 100-04, Chapter 12
http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf
To determine the global period of a surgery, refer to the Medicare Physician Fee Schedule database (MPFSDB)on the CMS Website:
http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=2.

EYE

Use the appropriate modifier for additional information when billing eye procedures.

-AP Determination of refractive state was not performed in the course of diagnostic ophthalmologic examination

- May be submitted with CPT codes 92002, 92004, 92012 and 92014.
- Because this modifier is informational only, submit in the last modifier position after any other appropriate modifiers.

-LS FDA- monitored intraocular lens implant

- Submit this modifier on physician claims for eye surgery with IOL implants

-VP Aphakic patient

- Submit this modifier with Evaluation and Management (E/M) codes or eye exam codes to indicate that the patient is aphakic.
- This modifier is informational only.

The following modifiers are often used for procedures or diagnostic tests that may be bundled when performed on the same eye(s):

-E1 Upper left eyelid
-E2 Lower left eyelid
-E3 Upper right eyelid
-E4 Lower right eyelid