Page Wolfberg & Wirth

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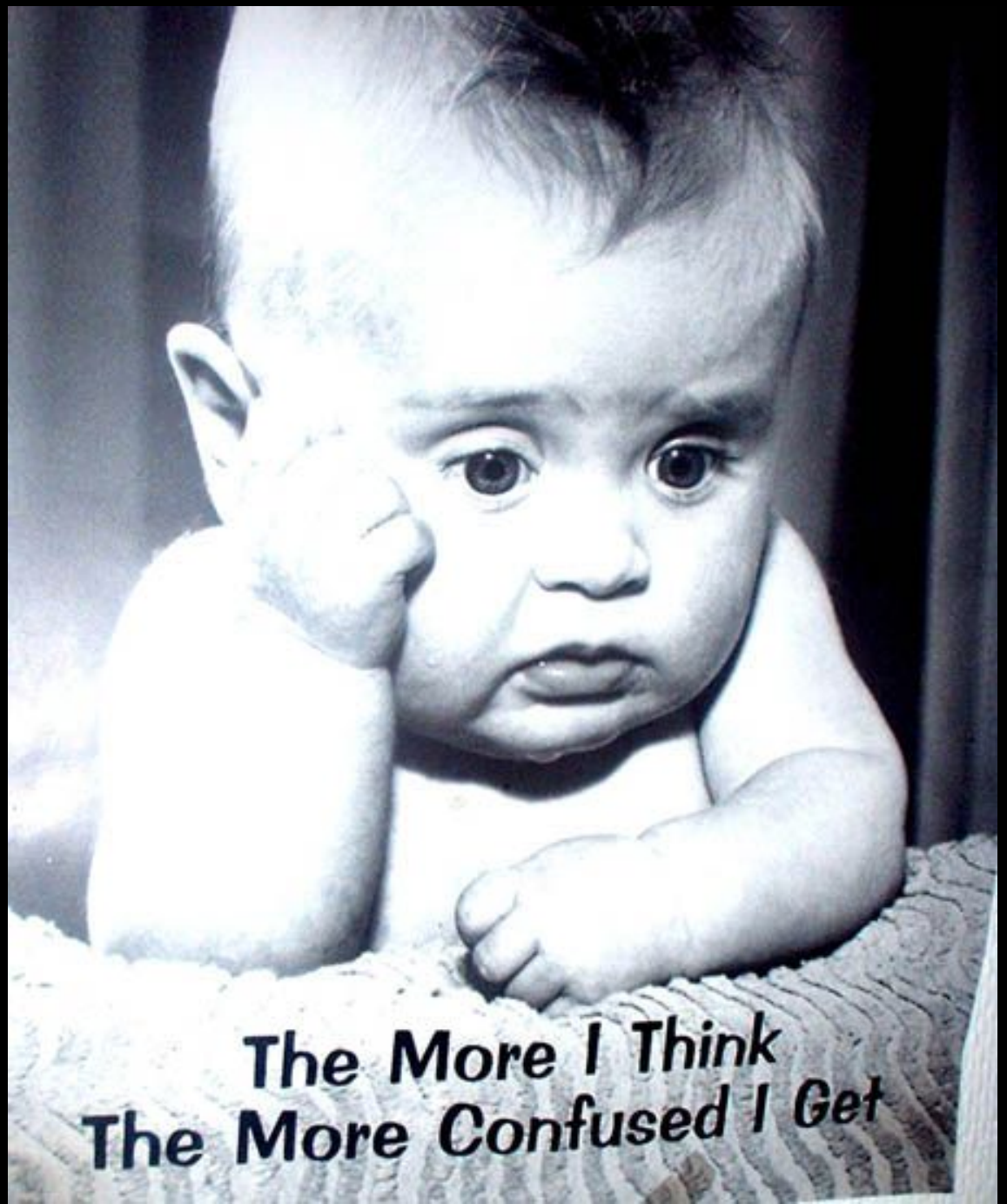
A DEEP DIVE INTO THE ORIGIN AND DESTINATION MODIFIERS:

There's More Than Meets the Eye

One would think this should be easy…


The More I Think
The More Confused I Get

Understanding Modifiers

- Origin and destination modifiers communicate the point of pickup and the destination
- In some situations they can also serve as indicators of specific coverage criteria considerations and compliance concerns

Modifiers Do Not Establish Payment Policy

- It is important to remember that modifiers are intended to describe, not to establish payment policy
  - For example, there is a modifier "P," which indicates a "Physician's Office"
  - However, Medicare guidelines do not cover transports to physicians' offices in the vast majority of situations
  - The fact that a "P" modifier exists does not mean that a physician's office is always a covered destination

Of the 11 possible Origin/Destination modifiers, several are pretty straightforward . . .

Well, OK, 2 of them are . . .

- G: Hospital based ESRD facility
- J: Freestanding ESRD facility

Which leaves only about 82% of them that cause frequent confusion and misunderstandings

Places People Live

- N: Skilled Nursing Facility
- E: Residential, Domiciliary, Custodial Facility
- R: Residence

Places People Go For Care

- H: Hospital
- D: Diagnostic or Therapeutic site
- P: Physician's Office

Other Origins/Destinations

- S: Scene of Accident or Acute Event
- I: Site of Transfer Between Modes of Transport
- X: Intermediate Stop at Physician's Office On Way to Hospital

It Is Not Always Easy

- While a doctor's office on Main Street may be clearly distinguishable from a hospital, the distinctions are not always that clear in today's complex healthcare environment
  - In some cases you may find a doctor's office located inside a hospital

Physician's Office vs Hospital

- Many ambulance services have faced Medicare audits and OIG investigations over the practice of billing certain destinations as an "H" (Hospital) – which is a Medicare covered destination – when they actually should have been coded as a "P" (Physician's Office) – which is typically not a Medicare covered destination

Physician's Office vs Hospital

- Always keep in mind that just because the services may have been delivered to the patient within the bricks and mortar of a hospital building, does not mean that they were "hospital services"

You can't just go by the ***building***…

…you must also look at the ***services***

Destination Modifier – Service vs. Building

- In selecting a modifier, it is usually best to consider the service or treatment the patient is being transported for, rather than the building they are being transported to

Destination Modifier – Service vs. Building

- It may be helpful to find out the NPI used on the claim for the services the patient received at that destination

Other Ways to Verify Facility Types

- It may be useful to consult the licensing website of the state agency that licenses health care facilities in your state
  - Usually this is the Department of Health

Pennsylvania Department of Health

Health Care Facilities

Search Procedure:

1) Select the type of facility you are interested in: Hospital

2) Choose **only one** of these three choices:

County: DAUPHIN
City: - All Cities -
Zipcode:

3) Enter the full or partial name for the facility you want. Leave this blank if you are unsure.

Name:

4) Enter the full or partial name for the facility owner you want.

Name:

Submit Reset

Back to County Map

Pennsylvania Department of Health

Health Care Facilities

ZipCode: -Not Selected- **City:** -Not Selected- **County:** DAUPHIN **Facility Type:** 01 **Partial Name:** -Not Selected- **Partial Facility Owner:** -Not Selected-

HELEN M. SIMPSON REHABILITATION HOSPITAL
Type of facility: Hospital
Status: Open
4300 LONDONDERRY ROAD
HARRISBURG, PA 17109
(717)920-4300

Click Here for Patient Care Survey Data

Click Here for Building Safety Survey Data

MILTON S HERSHEY MEDICAL CENTER
Type of facility: Hospital
Status: Open
500 UNIVERSITY DRIVE
P.O. BOX 850
HERSHEY, PA 17033
(717)531-8323

Click Here for Patient Care Survey Data
Click Here for Building Safety Survey Data

MILTON S HERSHEY MEDICAL CENTER - TRANSPLANT CENTER
Type of facility: Hospital
Status: Open
500 UNIVERSITY DRIVE, P. O. BOX 850
HERSHEY, PA 17033
(717)531-8521

Click Here for Patient Care Survey Data

No Available Building Safety Surveys

PENN STATE HERSHEY REHABILITATION LLC
Type of facility: Hospital

Other Ways to Verify Facility Types

- You can also ask the facility for license documentation
- This may be useful for “hybrid” or “mixed bed” facilities

Other Ways to Verify Facility Types

- In any event, it may take a little bit of legwork and research to accurately determine facility types – and therefore proper modifier selection

Consider Various Payer Policies

- Of course, it is also important to remember that destination coverage rules may vary by payer
  - For example: While Medicare usually does not cover ambulance transports to a physician's office, other payers (such as some state Medicaid programs) sometimes do
  - Check your state Medicaid rules!

Now For a Deeper Dive Into The 82%

the Deep Dive

Places People Live

N = Skilled Nursing Facility

Also Known As an “1819 Facility”

N – Skilled Nursing Facility

- Social Security Act §1819. **[**42 U.S.C. 1395i–3**]**
  (a) Skilled Nursing Facility Defined. – In this title, the term "skilled nursing facility" means an institution (or a distinct part of an institution) which –

N – Skilled Nursing Facility

- (1) is primarily engaged in providing to residents
  - (A) skilled nursing care and related services for residents who require medical or nursing care, or
  - (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases;

N – Skilled Nursing Facility

- (2) has in effect a transfer agreement (meeting the requirements of section 1861(l)) with one or more hospitals having agreements in effect under section 1866; and

N – Skilled Nursing Facility

- (3) meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of this section.
  - (b) Requirements Relating to Provision of Services
  - (c) Requirements Relating to Residents' Rights
  - (d) Requirements Relating to Administration and Other Matters

N – Skilled Nursing Facility

- When Medicare talks about “facilities” this is one of the types of entities they are referring to
- One of 2 modifiers that qualifies as an origin or destination for an SCT transport (“H” and “N”)
- Use of the “N” modifier implies potential application of “Part A” rules

N – Potential For Confusion

- Ambulance transports to or from a diagnostic or therapeutic site other than a hospital or renal dialysis facility (e.g., an independent diagnostic testing facility (IDTF), cancer treatment center, radiation therapy center, wound care center, etc.) of a patient in their Part A SNF stay is not a separately payable Part B covered service.
  - Billable to the SNF

Medicare Claims Processing Manual, Chapter 15 §30.2.2

N – Potential For Confusion

- For a SNF resident outside their Part A stay, transport from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, including the return trip, is a separately payable Part B covered service.
  - MACs will often get this one wrong

42 CFR §410.40 (e)(3)

N – Potential For Confusion

- Some hospitals have been approved by CMS to provide “Swing Bed Services” (SNF level care)
  - In some cases may be a specific floor or department of the hospital
  - Modifier for a patient in one of these beds is “N” not “H”

N – Potential Compliance Issues

- If a patient is transported from a "Swing Bed" in a hospital to a free standing SNF, using the "H" modifier for the origin could be seen as an attempt to make the transport appear to be a separately payable Part B covered service (H–N) when in fact it is not (N–N)
  - Discharge of a patient, in their Part A stay, from one SNF with admission to another SNF prior to midnight of the same day is billable to the first SNF

Residential Facility vs. SNF

- The “N” modifier describes a Skilled Nursing Facility (SNF)
- A non-skilled facility, such as an assisted living facility, a personal care home, or other such residential facility – if not licensed as a SNF – should not be coded as an “N”, but rather as an “E”

E = Residential, domiciliary, custodial facility

(other than 1819 facility)

E – Most Commonly Applies To

- Assisted Living
- Residential Care Facility
- “Personal Care Home”

E – Potential for Confusion

- Some facilities may be called a “Nursing Home” but may not be an “1819 Facility”
- In this case the appropriate modifier is “E” not “N”

E – Potential Compliance Issues

- Coding a location as an “E” when it should be coded as an “N” could be seen as an attempt to avoid “Part A” rules and make a transport separately payable by Part B when it should not be

R = Residence

R – Residence

- This is the modifier to use for the patient's residence

R – Potential for Confusion

- It does not mean “a private residence”, it means “the patient’s private residence”
  - If an ambulance picks me up at my house, the correct modifier is “R”
  - If an ambulance picks me up at your house, the correct modifier is “S”

R – Potential Compliance Issues

- It is true that some people live at a SNF
- *However*, coding a location as an "R" when it should be coded as an "N" could also be seen as an attempt to avoid "Part A" rules and make a transport separately payable by Part B when it should not be

When More Than One Could Apply, Always Use the Most Specific Modifier

Scene vs. Residence

- For example: a patient fell down the steps at home
- Both “S” (Scene of Accident) and “R” (Residence) modifiers seem to describe the origin of the transport
- However, the “R” modifier is more specific and descriptive of the scene of the accident in this case, therefore “R” is the appropriate modifier to use on the claim

Another Example: “R” vs. “E”

- Since it is true that many patients live at an Assisted Living Facility, it seems logical that either “R” or “E” could describe the origin of the transport in these cases
  - The “E” modifier is more specific and better describes the patient’s domicile in this case

Places People Go For Care

H = Hospital

H – Potential for Confusion

- "Hospital" may seem self explanatory, especially when used as a destination
- But, it is important to ascertain the nature of the services for which the patient is being transported
- You cannot simply look at the building to which the patient is being transported

H – Potential for Confusion

- If in doubt, best to determine the Medicare Provider Number under which the services the patient receives will be billed

H – Potential Compliance Issues

- Make sure that transports to services like doctors appointments, or diagnostic or therapeutic services, provided by suppliers inside the hospital, but not billed by the hospital are not incorrectly billed using the “H” destination modifier

What About a Free Standing ER?

- May be able to determine the appropriate modifier using the facility's NPI and the NPPES search
- May be able to determine using the facility's Medicare Provider Number, or CMS Certification Number (CCN)
  - Formerly OSCAR Number
  - Using information in the State Operations Manual, (Pub.100-07) Chapter 2

What About a Free Standing ER?

- Are transports from a free standing (or off-campus) ER, billing under a hospital's CCN, to that hospital separately payable by Part B?
  - Must use the "3 Part Test" for interfacility transports to make this determination
  - If same provider number, different campus – depends on whether/when the patient was admitted as an inpatient

D = Diagnostic or Therapeutic Site

other than P or H when these are used as origin codes

D – Diagnostic or Therapeutic Site

- Medicare makes a distinction between free-standing and hospital-based locations
- Independent diagnostic or therapeutic sites, not part of a hospital, are not Part B covered destinations
  - With 2 exceptions:

Exception #1

- Free-standing dialysis (“J” modifier)

Exception #2

- Transport of a patient from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, including the return trip
  - 42 CFR 410.40(e)(3)
- Therefore, “N” to “D” (or N-P) transports and the return trip could be covered if medical necessity and other coverage criteria are met

Remember…

- Even though these N-D and D-N round trips can be covered, medical necessity and reasonableness must always be met (and accurately documented)
- "Reasonableness" will be tricky, because you have to be able to demonstrate that the patient required services that could not more economically be provided at the SNF

D – Potential for Confusion

- Remember: In selecting a modifier, it is usually best to consider the service or treatment for which the patient is being transported, rather than the building to which they are transported
- For example, if a patient is being transported to a doctor's office for diagnostic or therapeutic services, "D" (not "P") is the correct destination modifier

D – Potential Compliance Issues

- Previously mentioned – coding destination modifier "H" for transports to diagnostic or therapeutic services, provided by suppliers inside the hospital or on a hospital campus, but not billed by the hospital

P = Physician's Office

P – Physician's Office

- Not a covered destination under Part B

P – Potential for Confusion

- Remember – code the destination based on the service for which the patient is being transported, not the building
  - If the patient is being transported for a doctor's appointment "P" is the correct modifier
  - If the patient is being transported for diagnostic or therapeutic services "D" is the correct modifier

P – Potential Compliance Issues

- Previously mentioned – coding destination modifier "H" for transports to a doctor's appointment, provided by suppliers inside the hospital or on a hospital campus, but not billed by the hospital

Other Origins / Destinations

S = Scene of Accident or Acute Event

S – Scene of Accident or Acute Event

- When none of the other modifiers describes the origin

S – Potential for Confusion

- While it might seem logical that every ambulance transport originates at "the scene of the accident or acute event", the fact that any other origin modifier is ever needed on a claim is evidence that when a more specific modifier exists, the more specific modifier is to be used

S – Potential Compliance Issues

- Coding an origin location as an “S” when it should be coded as an “N” or “H”, for example, could be seen as an attempt to avoid “Part A” rules and make a transport separately payable by Part B when it should not be

I = Site of Transfer Between Modes of Ambulance Transport

(e.g. airport or helicopter pad)

I – Site of Transfer Between Modes

- The “I” modifier can be used as either an origin or destination modifier in transfer of care with “Change in Mode” situations
  - Transfer from Air Ambulance to Ground Ambulance
  - Transfer from Ground Ambulance to Air Ambulance

Site of Transfer – Example

- MVA patient is transported by a ground ambulance from the scene of an accident to a landing zone to be transferred to an air ambulance, then transported by helicopter to the hospital
- Origin/destination combination:
  - Ground ambulance: “SI”
  - Air ambulance: “IH”

I – Potential for Confusion

- If a patient is transferred from one ground ambulance to another ground ambulance, the “I” modifier is not appropriate as there was no “Change in Mode”

I – Potential Compliance Issues

- If a ground ambulance crew assists an air ambulance crew at a scene and, for example, simply rolls the patient on the ground crew's stretcher to the air ambulance; since there was no transport of the patient by the ground ambulance vehicle (therefore vehicle requirements not met) there is no ground component billable to Medicare

I – Potential Compliance Issues

- *However,* the ground and air services could have an agreement by which the air service compensates the ground service for its reasonable costs of providing care prior to the air transport
- These arrangements are permissible, but be sure they remain compliant with the anti-kickback statute (obtain qualified legal counsel)

X = Intermediate Stop at Physician's Office On Way to Hospital

“X” – Intermediate Stop at Physician’s Office

- Can only be used as a destination code

"X" – Intermediate Stop at Physician's Office

- Ambulance is enroute to a Medicare covered destination, and
- During the transport, the ambulance stops at a physician's office because of the patient's dire need for professional attention, and immediately thereafter, the ambulance continues to the covered destination

Medicare Benefit Policy Manual, Chapter 10, Section 10.3.8

"X" – Intermediate Stop at Physician's Office

- This would be an extremely unusual coding situation
  - In fact, we've never seen this modifier used on any claim we've reviewed
- To use it would mean that the ambulance service was submitting 2 claims for the transport of the patient, for example, from a Scene to the hospital:
  - First Claim – "SX"
  - Second Claim – "PH"

A Couple of Tricky Origin/Destination Issues

"QL" Calls

Treat-No-Transport Calls

QL/Treat-No-Transport

- Both of these situations are non-transport calls
- QL = pt pronounced dead after dispatch, before transport
- In this situations, it is important to check with your MAC on their modifier preference for these type of claims

QL/Treat-No-Transport

- Some MACs prefer no modifiers on these claims, and others prefer that you use the same origin modifier twice
  - Example: R-R or S-S

Remember…

- QL is reimbursed at the BLS rate regardless of whether or not there was an ALS assessment or ALS interventions
- Treat-No-Transport is not reimbursed by Medicare
  - Be sure to use the GY modifier on these
  - However, other payers may cover treat-no-transport

A Quick Look at Non-Covered Service Modifiers

Non-Covered Service Modifiers

- GA, GY, GZ, GX
- These modifiers are used when the services provided are not covered
- This is often referred to as “billing for denial”

Why Bill for Denial?

- Medicare rules require that a provider or supplier submit a claim to Medicare when the beneficiary requests it
  - A denial from Medicare triggers a beneficiary's right to an appeal
- Some secondary payers may require a denial from Medicare to process a claim (coordination of benefits)

Non-Covered Service Modifiers Are Your Friend

- If an ambulance service submits a claim for a non-covered service without using a denial modifier, it could be construed as a potential false claim
- The denial modifiers – or non-covered service modifiers – signal to Medicare (or other insurer) that you're not asking for payment

Patient Liability

- It is important to use the proper non-covered service modifier, because it could affect your ability to bill the patient

GA Modifier

- Use in a situation where an ABN is required, and an ABN was obtained prior to the transport
- Beneficiaries are liable – and may be billed – for the service, because they were first notified of non-coverage

GZ Modifier

- Use in a situation where an ABN is required, and no ABN was obtained prior to the transport
- Beneficiaries are not liable – and should not be billed – for the service, because the provider/supplier failed to notify them of non-coverage, but was required to

Beneficiary Liability – GA and GZ

- Obviously, the ambulance service should take all necessary compliance steps to minimize how often it must use a GZ modifier
- This is a significant call intake issue, since ABNs must be obtained prior to the transport

GX Modifier

- May be used in a situation where an ABN was optional, but was obtained prior to the transport
- May also use GY modifier in these situations

GY Modifier

- GY modifiers describe services that are non-covered because they are statutorily excluded
- Some examples:
  - Non-medically necessary services
  - Wheelchair van transports
  - Transports to non-covered destinations

Beneficiary Liability - GY

- The beneficiary is liable – and may be billed – for non-covered services that fall under the GY modifier

Summary

- Focus on the service / treatment the patient is being transported for, rather than the building they are being transported to
- Research when unsure, based on NPI or CCN
- When more than one modifier could apply, use the most specific modifier