Modifiers:
How to Choose What to Use

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Objectives

- Develop an increased understanding of E/M and surgical modifiers
- Identify correct usage of modifiers within the global surgical period
- Address appropriate utilization of modifiers pertinent to the 2012 OIG Work Plan
- Review new modifiers for 2011-2012

CPT® Surgical Package Definition

Services included in addition to the surgical procedure:

Pre-operative
- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Subsequent to the decision for surgery, one related Evaluation and Management (E/M) encounter on the date immediately prior to or on the date of procedure (including history and physical)

Post-operative
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
- Writing orders
- Evaluating the patient in the post anesthesia recovery area
- Typical postoperative follow-up care
  *Only the operating surgeon is linked to the global period*
CMS Definition of Global Period

- **Minor procedures:**
  - 0 to 10 day global period after procedure
- **Major procedures:**
  - 1 day prior and 90 days after procedure

- Global Period Calculator (MPFSDB),
  [http://www.cms.hhs.gov/pfslookup/02_PFSsearch.asp](http://www.cms.hhs.gov/pfslookup/02_PFSsearch.asp)
  - 000 = 0 global days
  - 010 = 10 global days
  - 090 = 90 global days
  - YYY = carrier determines global period
  - ZZZ = add-on codes
    - Global period is determined by the primary surgical procedure performed

Evaluation and Management (E/M) Only Modifiers*

- Modifier 24
- Modifier 25
- Modifier 57

- Append to CPT Codes 99201 - 99499
  * Can also append to ophthalmology codes 92002 - 92014
Modifier 24

*Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period*

- Shows that this E/M is not part of “global surgical package”
- Usually, but not necessarily, different diagnoses

**Modifier 24 Coding Scenario 1**

- May 1st: Appendectomy (44950)
  - Acute appendicitis (540.9)

- May 19th: Same operating surgeon with
  - New onset RUQ abdominal pain (789.01)

- Code:
  - 99213-24
  - Diagnosis: (789.01)
    - The diagnoses are different
Modifier 24 Coding Scenario 2

- June 1st: Closed treatment of metacarpal fracture, single; without manipulation, each bone
  - Code: 26600-F1, 90-day global period
    - Diagnosis: (815.03) fracture of metacarpal bone, shaft of metacarpal bone

- July 1st: Patient presents to same operating surgeon
  - Diagnosis: (815.03) fracture of metacarpal bone, shaft of metacarpal bone
    - Different finger, F6
  - Code: 99213-24
    - Diagnosis: (815.03), fracture of metacarpal bone….F6
    - Same diagnosis; unrelated to previous surgery

Modifier 25

*Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service*

- Indicates a separate service from that required for the procedure
- A clearly documented, distinct, and significantly identifiable service was rendered
- *Intent* of, or reason for, visit is important
Modifier 25 Coding Scenario 1

- Established patient complains of **left eye pain**
  - Symptom diagnosis, reason for visit: (379.91)
- Physician removes foreign body from cornea
  - Code:
    - 99212-25, Office visit
    - 65220-LT, Removal of FB, cornea, LT eye
      - Diagnosis: Corneal FB (930.0) (Definitive diagnosis)

  - Or for eye examination, code:
    - 92012-25, 65220-LT

Modifier 25 Utilization
E/M and Preventive Medicine Service Provided on the Same Date

- Per CMS: “Medicare payment can be made for a significant, separately identifiable medically necessary E/M service (CPT codes 99201-99215)

- Billed at the same visit as the Initial Preventive Physical Examination (IPPE) or Annual Wellness Visit (AWV) when billed with modifier 25

- That portion of the visit must be medically necessary to treat the beneficiary’s illness or injury, or to improve the functioning of a malformed body member.”
Modifier 25 Coding Scenario 2

- Established patient (35 years old) preventive exam
- Established patient E/M service
  - Code:
    - 99212-25: Examination and diagnosis of ankle sprain (845.00)
    - 99395, Preventive Comprehensive Preventive Medicine; 18 -39 years (V70.0)
  - For Medicare IPPE and AWV:
    - HCPCs code G0402 (IPPE), 99212-25
    - HCPCs code G0438/G0439 (AWV), 99212-25

Modifier 57

*Decision for Surgery*

- Designed to be used with major surgeries
  (Usually 90 global day period)
- May be the same or different diagnoses
- Use on the day of or day prior to major surgery
Modifier 57 Coding Scenario

- Patient presents to ED
  Acute RLQ abdominal pain & fever (789.03, 780.60)

- ED physician calls for surgical consult (99243)
  - non-Medicare patient
  - Surgeon decides at that visit to perform an emergency appendectomy (44950)

- Code:
  - 99243-57, 44950
  - Diagnosis: (540.9) Acute appendicitis

Surgery Modifiers

Related to the Global Period

- Modifier 58
- Modifier 78
- Modifier 79

Other Common Surgery Modifiers

- Modifier 50
- Modifier 51
- Modifier 59
Modifier 58

Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

• Append to CPT code when the procedure is secondary and/or related to the original or first procedure
  – Planned prospectively at the time of the original procedure (staged)
  – “More extensive” than the original procedure
  – Therapy following a diagnostic surgical procedure

• New global period begins with each subsequent procedure
• Used only during the global surgical period for the original procedure
• Cannot be used for staged procedures when the code description indicates "one or more visits" or "one or more sessions"
• CPT Descriptor Note: “For treatment of a problem that requires a return to the operating room use modifier 78”
Modifier 58 Coding Scenario 1

Planned prospectively

• Cheek-to-nose flap in 2 stages
  • May 1st: Formation of direct or tubed pedicle
    • Code: 15576, Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral (90 global days)
  • June 1st: Delay of flap
    • Code: 15630-58, Delay of flap or sectioning of flap (division and inset); at eyelids, nose, ears, or lips

Modifier 58 Coding Scenario 2

More extensive than original procedure

• Diagnostic procedure and subsequent surgery
  • May 1st, Code:
    • 19120-RT, Removal of breast lesion, (90 global days)
    • Diagnosis: (239.3) Neoplasm of unspecified nature, breast
  • May 9th, Code:
    • 19307-58-RT, Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle
    • Diagnosis: (174.1) Neoplasm, malignant, breast, central portion
Modifier 78

Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

- Treatment for complications requires a return to the operating or procedure room
- The procedure would not have been necessary if the first procedure had not been performed

Examples

- Post-surgical infection
- Debridement in the operating room
- Hemorrhage after surgery

- Modifier that does not reset global days from previous surgery
  - Usually not reimbursed at 100% of the allowed amount
- Diagnosis is different for each procedure
- Requires the use of operating or procedure room
Modifier 78 Coding Scenario

- May 1st: Patient undergoes partial colectomy (90-day global)
  - Code:
    - 44140, Colectomy, partial; with anastomosis
    - Diagnosis: (153.3) Malignant neoplasm of colon, sigmoid colon

- May 14th: Patient is returned to the operating room for treatment of partial dehiscence of the incision with secondary suturing of the abdominal wall.
  - Code:
    - 49900-78, Suture, secondary, of abdominal wall for evisceration or dehiscence
    - Diagnosis: (998.32) Other complications of procedures, NEC; disruption of wound; disruption of external operation (surgical) wound

 Modifier 79

Unrelated Procedure or Service by the Same Physician During the Postoperative Period

- Appended to surgery codes to indicate that an unrelated procedure was performed by the same physician during the postoperative period of the previous procedure

- New global period begins
Modifier 79 Coding Scenario 1

- May 1st, 9:00 am: Closed fracture of the right ulna (813.22) in ED
  - Code:
    - 25535-RT: Closed treatment of ulnar shaft fracture; with manipulation
    - Diagnosis: (813.22) Fracture of radius and ulna; shaft, closed; ulna (alone)
- May 1st, 1:00 pm: Patient returns to ED with uncontrollable nosebleed (784.7). Sees same physician.
  - Code:
    - 30905-79: Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial
    - Diagnosis: (784.7) Epistaxis

Modifier 79 Coding Scenario 2

- May 1st: Cataract removal on right eye
  - Code:
    - 66984-RT, Extracapsular cataract removal with insertion of intraocular lens prosthesis, manual or mechanical technique (90-day global)
    - Diagnosis: (366.16) Nuclear sclerosis (cataract)
- June 1st: Cataract removal on left eye
  - Code:
    - 66984-79-LT
    - Diagnosis: (366.16) Nuclear sclerosis (cataract)
Modifier 79 Abuse

Inappropriate Use Example:

- OIG Investigation
  - Revealed provider billed for surgeries every 5 to 6 days
  - Used modifier 79 on every surgery
  - Abuse of Modifier 79 enabled him to defraud the Medicare program from 1994 to 2000

Modifiers 79 Checklist

- Does the subsequent procedure take place on a different body part?
- Is the subsequent procedure linked to a different diagnosis?
- Was the subsequent procedure prospectively planned?
## Global Modifier Chart

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<tr>
<th>If...</th>
<th>Then use...</th>
<th>On the...</th>
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<tr>
<td>You are seeing the patient for an unrelated E/M service during a postoperative period,</td>
<td>Modifier 24</td>
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<td>You are performing an unrelated (usually different diagnosis) E/M service on the day of a minor procedure,</td>
<td>Modifier 25</td>
<td>E/M code</td>
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<td>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. Note: 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.</td>
<td>Modifier 25</td>
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<td>You make the decision to perform a major surgery the day of or day prior to the surgery,</td>
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<td>You are performing a “more extensive” procedure or performing procedures in stages, in a postoperative period,</td>
<td>Modifier 58</td>
<td>Surgery code</td>
</tr>
<tr>
<td>The patient needs additional surgery due to complications of the original surgery and is returned to the operating room,</td>
<td>Modifier 78</td>
<td>Surgery code</td>
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<tr>
<td>The patient has an unrelated surgery during the postoperative period of the original surgery,</td>
<td>Modifier 79</td>
<td>Surgery code</td>
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Adapted from: www.trailblazerhealth.com

## Modifier 50

**Bilateral procedure**

- Use only when the code description does not already state it is bilateral
- Per CMS, “One or both” in the description—do not use modifier 50
- Payment is 150% of allowable

**Bilateral Indicators:**
  - 0 = Bilateral does not apply
  - 1 = Valid for bilateral - criteria does apply
  - 2 = Money is already established for bilateral.
  - 3 = Radiological procedures or diagnostic tests. Bilateral criteria does not apply
Modifier 51

Multiple Procedures

- Same Procedure, Different Sites
- Multiple Operation(s), Same Operative Session
- Procedure Performed Multiple Times
- List most resource intense first

- Multiple procedure discount

- Subsequent procedures with −51 (unless code is −51 exempt)
- CPT Appendix E lists codes that are exempt from Modifier 51
Modifier 51 Coding Scenario

Multiple operations in the same operative session

- 11600: Excision, malignant lesion, trunk, 0.5 cm or less
- 12032: Intermediate repair (layer closure) of wounds of trunk, 5.0 cm

- Code:
  - 12032 [100% reimbursement]
  - 11600-51 [50% reimbursement]

Modifier 59

Distinct Procedural Service

- Different session or encounter
- Different procedure
- Different site
- Separate incision, excision, lesion, injury, body part
Modifier 59 Coding Scenario:
“Separate Procedure”

- **Performed alone:**
  - 29870: Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
    - Code:
      - 29870-LT

- **As an integral part of another procedure:**
  - Diagnostic arthroscopy and surgical arthroscopy on right knee
  - Do not bill separate procedure
  - Code:
    - 29866-RT: Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft(s))

- **As a distinct procedure:**
  - Diagnostic arthroscopy on left knee and surgical arthroscopy on right knee in same surgical session
  - Code:
    - 29866-RT: Arthroscopy, knee, surgical...
    - 29870-59-LT: Arthroscopy, knee, diagnostic...

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Modifier 59 Coding Scenario:
Distinct Procedure, Site, Excision, Lesion

Excision of skin lesion on the right arm and biopsy of a separate skin lesion on the left arm

- **Right arm skin lesion excision, code:**
  - 11403, Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm
  - 216.6, Benign neoplasm of skin; skin of upper limb, including shoulder

- **Left arm skin lesion biopsy, code:**
  - 11100-59, Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion
  - 238.2, Neoplasm of uncertain behavior of other and unspecified sites and tissues; skin
The Great Debate: 51 vs. 59

- 2 procedures not usually submitted together but are proper under the circumstances
- Payer policy is crucial
- CCI Edits: When to Appropriately Unbundle

https://www.cms.gov/NationalCorrectCodInitEd/NCCIEP/list.asp

Correct Coding Initiative

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Adapted from:
https://www.cms.gov/NationalCorrectCodInitEd/NCCIEP/list.asp
OIG Targets

1. Evaluation and Management Services: Use of Modifiers During the Global Surgery Period

2. Medicare Payments for Part B Claims with G Modifiers

3. Medicare Payments for Durable Medical Equipment (DME) Claims With Modifier KX

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OIG Targets:
Evaluation and Management Services:
Use of Modifiers During the Global Surgery Period

- “(The OIG) will review the appropriateness of the use of certain claims modifier codes during the global surgery period and determine whether Medicare payments for claims with modifiers used during the global surgery period were in accordance with Medicare requirements.”
- “A specific audit looking at the use of the -25 modifier is recommended.”

- HHS OIG Work Plan | FY 2012
OIG Targets: Modifier 25

• Is the diagnosis the same?

• Does the documentation support a “separately identifiable E/M service”?

• What was the intent for the visit?

Examples of Inappropriate Use:

• Patient presents for a previously-scheduled procedure.

  • “Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed”

  • Medicare Claims Processing Manual Chapter 12, Section 40.1 G
OIG Targets: Modifier 25

- March 1st: Patient schedules removal of lesion
- March 3rd: Patient presents to office for removal of benign lesion, left arm, 1 cm.
  - No other problems are discussed in detail
  - Appropriate billing:
    - 11401 only
      - Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 cm to 1.0 cm

OIG Targets
Medicare Payments for Part B Claims with G Modifiers

Advanced Beneficiary Notice (ABN)
- Claims Medicare is expected to deny as not reasonable and necessary
  - GA: Waiver of liability statement (ABN) issued as required by payer policy, individual case
  - GZ: Item or service expected to be denied as not reasonable and necessary
- Claims for items or services that are statutorily excluded
  - GX: Notice of liability issued, voluntary under payer policy
  - GY: Item or service statutorily excluded, does not meet the definition of any Medicare benefit or for non-Medicare insurers, is not a contract benefit
OIG Targets
Medicare Payments for Part B Claims with G Modifiers

• Recent OIG review
  • Medicare paid for claims with GA or GZ modifiers
  • $4 million in potentially inappropriate payments
• Processing issue with the Fiscal Intermediaries (FI)
  • Cost physicians to refund money
  • Possible to correctly utilize these modifiers and still get paid

OIG Targets
Medicare Payments for Durable Medical Equipment (DME) Claims With Modifier KX

• OIG will “review appropriateness of Medicare Part B payments to DME suppliers”
• Modifier KX indicates: requirements specified in the medical policy have been met
• Recent audits have shown that “claims with Modifier KX may have been invalid and should not have been paid by Medicare”
Modifiers: What’s New

Modifier PD

“Diagnostic or related non-diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days”

- Expands “3-Day Payment Window Policy” to include non-diagnostic services
- Services provided by the hospital or an entity wholly owned or wholly operated by the hospital
  - Patient is admitted as an inpatient within 3 days
  - Diagnosis is “clinically related” to the admission
  - Payment is included in “operating costs of inpatient hospital services”

Modifiers: What’s New

Modifier 33: Preventive Services

“When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure.

For separately reported services specifically identified as preventive, the modifier should not be used.”

- Patient Protection and Affordable Care Act (PPACA)
  - Requires all health care insurance plans to begin covering preventive services and immunizations without any cost-sharing
Modifier 33: Preventive Services

• Applies to
  • CPT Preventive Medicine Codes 99381 – 99397
  • Medicare Annual Wellness Visit (AWV) HCPCS Codes G0438 and G0439
  • Counseling Risk Factor Reduction and Behavior Change Intervention section of CPT (99401–99429)

• Append Modifier 33
  • Services rated A or B by the US Preventive Services Task Force (USPSTF) www.uspreventiveservicestaskforce.org
  • Immunizations for routine use in children, adolescents, and adults as recommended by the Centers for Disease Control
  • Preventive care and screenings for children
  • Preventive care and screenings provided for women
    • Health Resources and Services Administration

Wrapping It Up

• Modifiers help to “tell the story” of the claim
• Review payer guidelines as well as CPT guidelines for modifiers to ensure correct usage
• Report modifiers appropriately based on documentation in the global surgical period
• Be aware of the 2012 OIG Work Plan
• Utilize new modifiers when applicable
Resources

• HHS OIG Work Plan | FY 2012
• Center for Medicare and Medicaid Services
  http://www.cms.gov
• US Dept. of Health and Human Services
  www.hhs.gov
• CPT® Assistant
• CPT® copyright American Medical Association,
  all rights reserved
• 2012 ICD-9-CM Volumes 1 & 2

Questions???

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