Modifiers:
How to Choose What to Use

AAPC National Conference
Las Vegas, Nevada
April 2012

Nancy Clark, CPC, CPC-I

AAPC

1

Disclaimer

The information in this presentation was current at the time the presentation was compiled. Always consult CPT®, CMS and commercial payers for specific guidance in reporting services. This presentation is designed to provide accurate information in regard to the subject matter covered. The information includes both reporting and interpretation of materials in various publications, as well as interpretation of policies of various organizations. Every reasonable effort has been made to ensure the accuracy of this information. The duplication of this presentation, all or in part, without the express permission of the presenter, is strictly prohibited.

AAPC

2

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

AAPC

3

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

AAPC

4

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

  - 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

AAPC

5

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

AAPC

6

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

AAPC

7

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

AAPC

8

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

AAPC
Credentialing the Business Side of Medicine

9

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

AAPC
Credentialing the Business Side of Medicine

10

Modifier 25 Coding Scenario 1

- Established patient complains of <u>left eye pain</u>
  - 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

AAPC

11

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 <u>must be medically necessary</u> to treat the beneficiary's illness or injury, or to improve the functioning of a malformed body member."*

AAPC

12

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

AAPC

13

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

AAPC

14

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

AAPC

15

Surgery Modifiers

Related to the Global Period

- Modifier 58
- Modifier 78
- Modifier 79

Other Common Surgery Modifiers

- Modifier 50
- Modifier 51
- Modifier 59

AAPC

16

Modifier 58

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

- Append to CPT code when the procedure is <u>secondary</u> and/or <u>related</u> 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

AAPC
Credentialing the Business Side of Medicine

17

Modifier 58

- 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"

AAPC
Credentialing the Business Side of Medicine

18

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

AAPC

19

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

AAPC

20

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 <u>complications</u> requires a return to the operating or procedure room
- The procedure would not have been necessary if the first procedure had not been performed

AAPC
Credentialing the Business Side of Medicine

21

Modifier 78

- 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 <u>different</u> for each procedure
- Requires the use of operating or procedure room

AAPC
Credentialing the Business Side of Medicine

22

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

AAPC
Credentialing the Business Side of Medicine

23

Modifier 79

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

- Appended to <u>surgery</u> 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

AAPC
Credentialing the Business Side of Medicine

24

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

25

Modifier 79 Coding Scenario 2

- May 1st: Cataract removal on <u>right eye</u>
  - 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 <u>left eye</u>
  - Code:
    - 66984-79-LT
    - Diagnosis: (366.16) Nuclear sclerosis (cataract)

26

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

CMS Pub 100-20 Transmittal 442 CR 6334

AAPC

27

Modifier 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?

AAPC

28

Global Modifier Chart

If…	Then use…	On the…
You are seeing the patient for an unrelated E/M service during a postoperative period,	Modifier 24	E/M code
You are performing an unrelated (usually different diagnosis) E/M service on the day of a minor procedure,	Modifier 25	E/M code
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.	Modifier 25	E/M code
You make the decision to perform a major surgery the day of or day prior to the surgery,	Modifier 57	E/M code
You are performing a "more extensive" procedure or performing procedures in stages, in a postoperative period,	Modifier 58	Surgery code
The patient needs additional surgery due to complications of the original surgery and is returned to the operating room,	Modifier 78	Surgery code
The patient has an unrelated surgery during the postoperative period of the original surgery,	Modifier 79	Surgery code

Adapted from: www.trailblazerhealth.com

29

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:
  - http://www.cms.gov/apps/physician-fee-schedule/?agree=yes&next=Accept

    - 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

AAPC

30

Physician Fee Schedule Search

HCPCS CODE	SHORT DESCRIPTION	BILT SURG	
68840	Explore/irrigate tear ducts	1	
			Valid for bilateral-criteria does apply
HCPCS CODE	SHORT DESCRIPTION	BILT SURG	
60220	Partial removal of thyroid, unilateral; with or without isthmusectomy	0	Bilateral does not apply
HCPCS CODE	SHORT DESCRIPTION	BILT SURG	
58210	Radical abdominal hysterectomy, w/ bilateral total lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)	2	Money is already established for bilateral

Adapted from: https://www.cms.gov/PhysicianFeeSched/

31

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

AAPC
Credentialing the Business Side of Medicine

32

16

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]

AAPC
Credentialing the Business Side of Medicine

33

Modifier 59

Distinct Procedural Service

• Different session or encounter

• Different procedure

• Different site

• Separate incision, excision, lesion, injury, body part

AAPC
Credentialing the Business Side of Medicine

34

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…

AAPC

35

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

AAPC

36

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

AAPC

37

Correct Coding Initiative

Column 1/Column 2 Edits	Column 2	*=In existence prior to 1996	Effective date	Deletion Date * = no data	Modifier 0=not allowed 1=allowed 9=not applicable
11403	11100		19970101	*	1
11403	11900		19960101	*	1
11403	11901		19960101	*	1
11403	12001	*	19960101	*	1
11403	12002	*	19960101	*	1
11403	12004	*	19960101	*	1
11403	12005	*	19960101	*	1
11403	12006	*	19960101	*	1
11403	12007	*	19960101	*	1
11403	12011	*	19960101	*	1
11100	99149		20091001	*	0
11100	99150		20091001	*	0
11201	10060		19960101	19960101	9
11201	10061		19960101	19960101	9

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

38
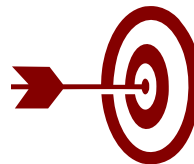
OIG Targets

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

AAPC

39

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

AAPC

40

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?

AAPC

41

OIG Targets: Modifier 25

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

AAPC

42

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

AAPC

43

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*

AAPC

44

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

AAPC
Credentialing the Business Side of Medicine

45

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*"

  •OAS; W-00-10-35305

AAPC
Credentialing the Business Side of Medicine

46

Modifiers: What's New

Modifier PD   Compliance Deadline: July 1, 2012

"*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"

AAPC

47

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

AAPC

48

Modifier 33: Preventive Services

NEW

- 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

AAPC
Credentialing the Business Side of Medicine

49

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

AAPC
Credentialing the Business Side of Medicine

50

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

AAPC

51

Questions???

Nancy Clark, CPC, CPC-I

NancyClarkCPC@gmail.com

AAPC

52