Effective Modifier Use for Proper Reimbursement

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Objectives

- Review common modifiers
- Look at case examples
- Apply payer guidelines
Effective Modifier Use for Proper Reimbursement

Modifier 25

Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service

What is significant and separately identifiable?

11401 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less

Pre-service:
- Benefits, risks, and alternatives to removal are explained
- Fresh history of medications taken is reviewed
- Review of pertinent problems that may have arisen since scheduling
- Consent obtained
Effective Modifier Use for Proper Reimbursement

**Modifier 25**

- 11401 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less

- **Post-service:**
  - Wound care reviewed
  - Instructions for problems are discussed
  - Restrictions on motion and activities reviewed
  - Prescriptions given if needed

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Effective Modifier Use for Proper Reimbursement

Modifier 25?

Pt comes in for FU of her HTN, hyperlipidemia, depression and has some musculoskeletal pain she is concerned about. She would like a skin lesion removed. She also requests a tetanus shot. She has some left shoulder pain that started about two weeks ago. It is not related to any increased activity, however. She points between her scapula and her spine when she brings her elbows back. No weakness in the upper extremities or numbness. No cough, no chest pain, no SOB.

Review of Systems: Essentially negative other than she has a lesion on her belly she would like looked at and removed if possible.

PHYSICAL EXAMINATION: Weight 241 #, BP 134/82, Pulse 68, Respiratory rate 16, Temperature 97. Eyes: anicteric. Ears: clear. Throat: normal. Neck: no JVD, no bruits. Abdomen reveals a flesh-colored lesion along the bra line, which is slightly irritated and erythematous. Extremities: no cyanosis, clubbing or edema. Shoulder reveals good ROM, some tenderness and spasm along the medial scapula on the left compared to the right. Distal neuro and vascular supply is grossly intact.

ASSESSMENT: HTN, hypercholesterolemia, musculoskeletal strain and depression.

PLAN: We will increase her Zoloft to 100 mg per pt request and have her stay on this for at least one year and wean off in the spring of next year. Today her lipids revealed LDL of 131, total cholesterol 220. We will continue with the Zocor given her two risk factors and her age. For HTN, continue Uniretic. Her abdomen was prepped and draped, and 1 cc of 1% Lidocaine was administered subcutaneously. A sharp excision was performed on the lesion, which measured approximately .5 cm, Hemostasis was achieved without any suture. Pt tolerated procedure well. Specimen was not sent because it is flesh-colored. Pt will FU as needed. Instructions were given for wound care.

Modifier 25?

The patient has been having problems with her distal femoral epiphysiodesis incisions. On Sunday, they swelled up significantly and were painful for her. She has not had any fevers or chills. She did do a previous course of Keflex.

Exam: She has full ROM of her knee. She has obvious swelling medially. Semi tender to palpation but particularly warm. The incision is well healed.

After sterilization with alcohol, and local anesthetic I aspirated 1 cc of cloudy fluid from the medial side of her knee. This was sent for cultures.

Radiographs: Standing AP view of the lower extremities shows hardware in good position.

Impression: Possible deep wound infection following epiphysiodesis.

Recommendations: We will get the results of her culture and call the family regarding treatment options. In the interim we restarted her on Keflex.
Modifier 25?

S. Continues to have achiness in her knees. Her current meds include ALEVE only as needed a few days out of the week as before. She is on LEXAPRO at night, XANAX, and CLONAZEPAM as needed. She is on a B12 injection once a month. We had given her a prescription for VICODIN but she lost the prescription.

O: Weight is 188 pounds. Blood pressure is 112/74. Pulse is 60. There is some crepitus at the knees without tenderness elicited. There is no active synovitis noted at this time. There is no alopecia noted on exam.

Review of lab work from April 29, 2013 revealed a negative ANA. Urinalysis had no blood or protein. Normal liver and renal function tests. Uric acid was normal with normal CRP, rheumatoid factor, anti-CCP, and TSH. Hemoglobin was 10.8 with MCV of 79.6 and normal white count and platelets.

A: Osteoarthritis of knees, Anemia

P: Patient was prescribed an IRON supplement, which she plans to start tomorrow. I did ask her to check with Dr. R about actual use of ALEVE given her anemia. Will start HYALGAN injections today. After informed consent, the left knee was steriley prepped. Used 1 cc LIDOCAINE for anesthesia. Injected the first of five HYALGAN injections, 2 cc, into the left knee without complications, followed by ice and rest. Follow up weekly for HYALGAN.

Modifier 25

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Source: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
NCCI Edits

“In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service.”

Modifier 25

United Healthcare & Texas Medical Association Webinar on Modifier 25, example of improper use:

A patient complained of left knee pain. The physician evaluated the knee and determined the patient would benefit from arthrocentesis. The physician gave the patient an injection and scheduled a follow-up visit for 1 month.
Effective Modifier Use for Proper Reimbursement

Blue Cross Blue Shield of Tennessee

Criteria

- There is documentation of a significant, separately identifiable E/M service which must contain the required number of key elements for the E&M service reported;
- The E/M service is provided beyond usual pre-operative, intraoperative, or postoperative care associated with a procedure performed on the same day;
- A symptom or procedure presents that prompts the E/M service (may not require a separate diagnosis);
- An initial hospital visit, an initial inpatient consultation, and a hospital discharge service is billed for the same date of service as an inpatient dialysis service;
- Critical care codes are billed within a global surgical period; or
- A medically necessary visit is performed on the same day as routine foot care.

Items that do not meet criteria

- E/M service that resulted in a decision for surgery;
- Ventilation management in addition to E/M services;
- Use on surgical codes;
- Use on same day of minor procedure;
- Use within global surgical period (pre- or postoperative care)

Blue Cross Blue Shield of Alabama

Criteria

- E/M involves separate and unique conditions, services, procedures, incisions, excisions or anatomical sites;
- Procedure and medically necessary E/M occur on the same day by the same provider;
- A decision is made to perform a minor procedure;
- The E/M service is above the usual preoperative, intraoperative, or postoperative care associated with the procedure that was performed and is no way related to the procedure code submitted;
- E/M visit is problem oriented and stands alone as a billable service

Items that do not meet criteria

- An E/M code is billed with major surgical procedures, chiropractic manipulations, or polysomnography; or
- Lab or x-ray services are the only other services provided in additional to the E/M; or
- The sole reason of the visit was for the procedure; or
- The E/M service is not above and beyond the primary purpose of the patient encounter; or
- Documentation does not support the definition of the modifier; or
- To bypass a fragmented coding edit.
Effective Modifier Use for Proper Reimbursement

Modifier 25 Appeal

- Does the documentation support two services?
- If I remove all of the documentation for one service, do I still have enough documentation to support the second service?
- Appeal letter – separate documentation into two services and send with letter.

Modifier 59

- Distinct procedural service
- Used to indicate:
  - Different surgical session
  - Different procedure or surgery
  - Different site or organ system
  - Separate excision or incision
  - Separate lesion or injury
**Effective Modifier Use for Proper Reimbursement**

- Do not use modifier 59 if there is a more appropriate modifier
- Review NCCI edits for Medicare and payers who use CCI Edits

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**NCCI Edits Example**

- **Example:** Column 1 Code/Column 2 Code 45385/45380
  - CPT Code 45385 - Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
  - CPT Code 45380 - Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
- **Policy:** More extensive procedure
- **Modifier -59 is:**
  1) Only appropriate if the two procedures are performed on separate lesions or at separate patient encounters.
Modifier 59

BlueCross BlueShield of Tennessee

Modifier 59 will only be recognized as valid to bypass edits when:

- Combination of procedure codes represent procedures that would not normally be performed at the same time;
- Different session or patient encounter is documented in patient’s medical record;
- Surgical procedures performed are not through the same incisional site (Note: doesn’t matter if instrumentation changes if incision or presentation is the same);
- Surgical knee procedures involving multiple compartments of the same knee; or
- Another modifier is not more appropriate.

Source: http://www.bcbst.com/providers/manuals/bcbstPAM.pdf

Modifier 59

Regence BCBS - Invalid use of modifier -59:

- Procedures in the same ipsilateral joint (including differing compartments) performed by open, scope, or combined open/scope technique, including added port or incisional sites. [Per Regence reimbursement policy the edits are applicable per entire joint and not per compartment within a joint]
- Procedures in the same anatomical site (e.g. digit, breast, etc.), even with incision lengthening or contiguous incision.
- CPT identified “separate” procedures performed in the same session, same anatomic site, or orifice.
- Scope procedure converted to open procedure.
- Incisional repairs are part of the global surgical package, including deliveries.
- Contiguous structures in the same anatomic site, organ system, or joint.

Modifier 59?

OPERATION:
Excision of right posterolateral lesion 6 mm, left hairline lesion 7 mm, and anterior midline lesion 6 mm with intermediate defect closure 9 mm, 11 mm, and 9 mm.

DESCRIPTION OF PROCEDURE:
The patient was brought to the procedure room. Using loupe magnification, lesions were all examined with the patient’s cooperation and participation. The lesions were then outlined as elliptical excisions and the areas infiltrated with lidocaine-epinephrine solution. The lesions were then excised to the level of subcutaneous tissue. The wounds were then closed by slight undermining the wound edges with re-approximation with 4-0 PDS deep dermal subcutaneous closure and 5-0 Prolene suture.

Modifier 59?

PREOPERATIVE DIAGNOSIS: Suspicious pigmented lesions x2 of right and left upper back.
POSTOPERATIVE DIAGNOSIS: Suspicious pigmented lesions x2 of right and left upper back.
OPERATION PERFORMED: Punch biopsy of left suspicious pigmented lesion and wide local excision with intermediate closure of the suspicious pigmented lesion of the right upper back lesion.
INDICATION: The patient is an 11-year-old white female with a history of enlarging, darkening lesions of her upper back x2.
DESCRIPTION OF PROCEDURE: The patient was placed in the prone position on the table. No sedation was given. Both areas of the right and left upper back were both prepped and draped in the sterile fashion with Betadine paint. The first area was located on the right upper back. This had a maximum diameter of 1 cm. This had a 3 mm margin designed for total resection of 1.6 cm. This was infiltrated with 1% Lidocaine with Epinephrine. It was excised, tagged, and sent for permanent pathology. The wound was then irrigated. Hemostasis was achieved. It was then closed in multiple layers with inverted dermises of 3-0 Vicryl, running subcuticular 4-0 Vicryl suture, as well as two 3-0 Vicryl, running total length of this incision was 2.8 cm. This area was covered with Steri-Strips, gauze and tape. The next lesion was located on the left upper back. This had a maximum diameter of 4 mm. A punch biopsy was taken. It was then sent for permanent Pathology. The area was irrigated. The wound was then closed with 5-0 chronic interrupted sutures. The area was washed and then a Band-Aid was applied. The patient tolerated this entire procedure with no complications and was sent home in stable condition.
Effective Modifier Use for Proper Reimbursement

Modifier 59 - Appeal

BlueCross BlueShield of Tennessee

Questions to ask regarding Modifier 59:
- What is the rationale for the existing edit?
- Is the edit a NCCI edit with an indicator ‘0’? If so, there is no appropriate modifier to allow edit bypass.
- Was the procedure performed in a separate setting, different time, or different encounter?
- Is there sufficient documentation to support the separateness and distinction of the two procedures?
- Was the procedure truly separate and/or is it unusual to perform these procedures at the same session?

Modifier 22

Increased Procedural service

Used to indicate the service provided required substantially greater work than typically required for a service of the same type.
Modifier 22

Examples:
- Excessive blood loss during the particular procedure
- Excessively large surgical specimen
- Trauma extensive enough to complicate the particular procedure and not billed as additional procedure codes
- Other pathologies, tumors, malformations (genetic, traumatic, surgical) that interfere directly with the procedure but are not billed separately.

WPS Medicare - Reimbursement will required review of documentation including:

- The unusual circumstances of the procedure
  “The ease or difficulty of a procedure generally falls within a bell curve with the lowest 2.5% of cases being extremely easy and the highest 2.5% of cases being substantially more difficult.”
- How the procedure differs from the “typical” service normally provided.
When the modifier 22 is used, two separate documents will be required to support the claim.

- An operative report and
- A separate statement indicating how the service differs from the usual

Please note - on April 28, 2012, if a separate statement describing the very unusual difficulty is not with the operative report, the 22 modifier will not be considered.

“When developing a separate statement avoid using a generalized statement. Comments like "patient was obese" or "surgery took longer than usual" or "multiple adhesions" lack specific details which identify why the procedure was beyond the normal difficulties that could be encountered with the procedure. Further, it is important that your operative note supports the statement on why the surgical procedure was beyond the ordinary range of difficulty.”
Occasionally a provider may perform two procedures that should not be reported together based on an NCCI edit. If the edit allows use of NCCI-associated modifiers to bypass it and the clinical circumstances justify use of one of these modifiers, both services may be reported with the NCCI-associated modifier. However, if the NCCI edit does not allow use of NCCI-associated modifiers to bypass it and the procedure qualifies as an unusual procedural service, the physician may report the column one HCPCS/CPT code of the NCCI edit with modifier 22. The Carrier (A/B MAC processing practitioner service claims) may then evaluate the unusual procedural service to determine whether additional payment is justified.
Modifier 22

Regence BCBS:

“In order to be considered for increased reimbursement, documentation from the patient’s record that will support the significantly greater effort performed must be submitted with the claim. It is not sufficient to simply document the extent of the patient’s illness or comorbid conditions that caused additional work. The documentation must describe additional work performed.”

Modifier 22?

Procedure:

Gastrostomy revision.
T-tube change.

History: This is 7-year-old male who is admitted to the GI service. Patient has a prolapse of what appears to be large amount of gastric mucosa out of G-tube site. Because of this, changing of his G-tube was felt indicated. He currently has a Foley in place.

Procedure: The patient was taken to the operating room, laid in supine position while general anesthesia was induced. The Foley was used to measure the tract length and the tract length was felt to be about 3.5 cm. A Foley was removed and abdomen was prepped and draped in usual sterile fashion. A large mass on the superior portion of the G-tube was excised along with a large amount of scar tissue. This was followed down to the gastric mucosa and the mucosa was sutured in a 180 degree fashion on the superior side to the skin. This made a nice gastrostomy tract. 8 ML 25% Marcaine was injected as a local block. Next, a 16 X 4.0 Boston Scientific G-tube was placed and the balloon filled. This seemed to fit fairly well. Antibiotic was placed on the wound. Patient tolerated procedure well, awoke in the recovery room in stable condition.
Modifier 22?

Procedure:
The patient was brought to the Operating Room and placed on the operating table in the supine position. General anesthesia was induced and she was prepped and draped in sterile fashion. Her ileal conduit was instrumented with silicone 14-French Foley catheter with return of yellow urine. The abdomen was then prepped with Betadine and latex allergy precautions were maintained throughout the procedure. Initial 3-cm incision was made superior to her previous lower midline scar and blunt dissection and Bovie electrocautery was down to the level of the anterior rectus fascia in the midline. Once this was identified, there was an obvious hernia, and this was incised. Two hours were spent in lysis of adhesions and to identify the point of obstruction, and the limits of the hernia. After the hernia defect had been identified in its entirety, there was no gross evidence of ischemic bowel, however, there was obvious obstruction, which went beyond what was visible. Her incision was opened both inferiorly and superiorly and the lysis of adhesions continued. Pneumatosis was identified in several locations in the mid small bowel and along with copious adhesions.....

Post-Operative Surgical Modifiers

• 58 – Staged or related procedure or service by the same physician during the postoperative period

• 78 – Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period.
Modifier 58

- Staged or related procedure or service by the same physician during the postoperative period.
- Used when:
  - The service is planned or staged
  - The service is more extensive than the original service
  - Therapy following a surgical procedure
- Not used when:
  - Reporting the treatment of a complication from the original surgery

Example: A breast biopsy is performed on 3/2/13. The patient is diagnosed with breast cancer and the same physician performs a modified radical mastectomy on the right breast on 3/6/13. The modified radical mastectomy would be submitted with modifier 58.
Effective Modifier Use for Proper Reimbursement

Modifier 58

NCCI

“If a diagnostic endoscopic procedure results in the decision to perform an open procedure, both procedures may be reported with modifier 58 appended to the HCPCS/CPT code for the open procedure.

However, if the endoscopic procedure preceding an open procedure is a “scout” procedure to assess anatomic landmarks and/or extent of disease, it is not separately reportable. “

Indication: This 44-year-old female with history of status post left upper extremity hand decompressive fasciotomy due to compartment syndrome. The patient has been brought previously for left upper extremity wound debridement and surgical bed preparation and preparation for application of full thickness skin graft to expedite wound closure and to allow earlier physiotherapy and return of function. The patient was planned to have a wound closure either in delayed fashion or with split-thickness skin graft during this operative encounter. The procedure was explained in full to the patient. She understands the risks include, but not limited to bleeding, infection, failure of the skin graft, need for further reconstructive surgery, loss of function, possible loss of limb. Informed consent was obtained.

Modifier 58?
Modifier 78

- Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period.

- Failure to submit the procedure with modifier 78 will result in claim denial.

- Example: Patient has a liver transplant on 3/2/13, on 3/3/13 the patient is returned to the OR and the physician re-opens the abdomen to control bleeding. Modifier 78 is appended to the procedure performed on 3/3/13.

Modifier 78?

**OPERATIVE INDICATIONS:** The patient is a 51 year old gentleman who yesterday I tried to revise his AV graft. I did a thrombectomy and balloon angioplasty and intraoperative arteriogram and it failed right away.

**OPERATIVE PROCEDURE:** The patient was placed in supine position, underwent uncomplicated general endotracheal anesthesia. I reopened his old incision, I then opened up the graftotomy and did a thrombectomy both sides, got good back bleeding, good inflow. I went ahead and shot an arteriogram. There was a small amount of what looked like pseudo-intima in the distal anastomosis of the venous that was causing a flow defect, I finally got that out with a Fogarty catheter and then I ballooned it up again with a 6 millimeter and a 7 millimeter Conquest balloon up to 30 atmospheres and then reshot the arteriogram in both directions. The arterial anastomosis looked fine as did the venous anastomosis except it was a little bit narrowed still but certainly much bigger than it was at the time of the first revision. I closed up the graftotomy with 5-0 Prolene, restored flow. There was a modest thrill but of course his blood pressure was only 90 so hopefully it will get better with time. We closed the wound with Vicryl and Dermabond and turned the patient over to anesthesia for wake up.
Modifier 78?

PROCEDURE: Exploratory laparotomy and removal of 2 liters of blood clots; ligation of omental bleeding vessel; removal of 6 lap pads and reapplication of wound VAC.

FINDINGS: Six lap pads that could be easily removed, large amount of hematoma and a small bleeding arterial in his omentum.

FLUIDS REPLACED: 1500 crystalloid.

DRAINS: Wound VAC.

INDICATIONS FOR PROCEDURE: The above patient was admitted following a head-on motor vehicle crash. He sustained multiple intra-abdominal injuries including a liver laceration and multiple bowel injuries. He had small bowel resection and was left in discontinuity. The patient was on Coumadin preoperatively and had significant bleeding intraoperatively. Additionally, his gonadal vein was avulsed from his inferior vena cava. Postoperatively the patient required massive fluid resuscitations of crystalloid and blood products. He required pressure release of his wound VAC earlier in the day and earlier in the afternoon he partially eviscerated from the bottom portion of his wound along the pelvis. We could only see purplish material underneath; it was unclear whether it was blood clots or ischemic bowel.

DESCRIPTION OF PROCEDURE: We removed his wound VAC, steriley prepped and draped him in the usual manner. We encountered a large amount of hematoma and evacuated approximately a total of 2 liters. The bowel was still protuberant but viable. We were able to identify at least one area that was in discontinuity. We removed 6 laparotomy pads from his bilateral pelvis; there was no bleeding in the area. We left the lap pads surrounding the liver. Additionally, there was one small artery in his omentum that had pulsatile bleeding and we ligated that with a Vicryl tie. We then irrigated the abdomen and reapplied a fenestrated bowel bag taking care to have the bowel bag extend into the gutters. We also applied an open abdomen wound VAC device and attained a good seal. The patient was taken back to the trauma ICU in still critical but hemodynamically stable condition. He tolerated the procedure well. Counts were correct during the case. He still has retained laparotomy pads. I do not know the exact number that are retained. We did however take 6 laparotomy pads out of his abdomen. I was scrubbed and present during this procedure.

Wrap Up

• Intent of modifier

• Documentation

• Payer Guidelines