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Rhonda Granja

On the topic:
Modifiers: Common Misuses and Other Trouble Spots
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Modifiers: Common Misuses and Other Trouble Spots

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CPT DEFINITION:

“A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance, but not changed in its definition or code. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities.”

• Always refer to Appendix A in CPT or HCPCS.

• AMA 2015 version – reference page # 679.
Modifiers...

impact your revenue dollars.
Many claims are kicked out
because of the use of, or lack
of, a modifier.

• Level I
  – CPT modifiers
    updated
    annually by
    AMA
    (American
    Medical
    Association)

• Level II
  – HCPCS modifiers
    updated by CMS
    annually
New for 2015  (EPSU Modifiers)

• XE Separate Encounter

• XP Separate Practitioner

• XS Separate Structure

• XU Unusual Non-Overlapping Service

XE (Separate Encounter)

• A service that is distinct because it occurred during a separate encounter.

  • Example: One surgery procedure at 9AM and one at 6PM.

  • Example: Group therapy services (97150) at 10AM and therapeutic exercises (97110) at 4PM.
XP (Separate Practitioner)

• A service that is distinct because it was performed on a separate organ/structure.

• Example: Patient seen by OB-GYN. During the exam, doctor notes an issue and requests his partner, a Perinatologist, examine the patient as well. Both practitioners fall under the same TIN.

XS (Separate Structure)

• A service that is distinct because it was performed on a separate organ/structure.

• Example: Injection into tendon sheath, elbow (20550) and injection into tendon sheath, knee (20550-XS).
XU (Unusual Non-overlap Service)

• A service that is distinct because it does not overlap usual components of the main service.

• *Example:* A diagnostic cardiac catheterization is followed by a medically necessary cardiac procedure.

Resources

• Medicare Learning Network: MLM MM8863

• Manual System: Transmittal 1422

Why need a subset of 59?

- CMS has stated some providers are using -59 to bypass NCCI Edits.
- It is associated with considerable abuse and high levels of manual audit activity, leading to review, appeals and even civil fraud and abuse cases.
- There is a projected 1 year error rate of $770 million between the providers and facilities.

Modifier 33

🌟 Adapted in 2011

- Preventive Service:
  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 appending modifier 33, Preventive Service, to the service. For separately reported services specifically identified as preventive, the modifier should not be used.
Modifier 33

• If you printed the materials from Medicare or ACOG prior to May of 2011, wrong instruction was given regarding the use of (33)....

Modifier 33

• EXAMPLE:
  Covered problem-oriented visit reported with a screening pelvic examination (G0101) and collection of a screening Pap smear specimen (Q0091).

<table>
<thead>
<tr>
<th>Bill to:</th>
<th>CPT/HCPCS Code(s)</th>
<th>ICD-9 Code(s)</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>99213-25</td>
<td>Problem diagnosis</td>
<td>$61.20</td>
</tr>
<tr>
<td></td>
<td>G0101-GA</td>
<td>V76.2, V76.47, V76.49</td>
<td>$34.60</td>
</tr>
<tr>
<td></td>
<td>Q0091-GA</td>
<td>V76.2, V76.47, V76.49</td>
<td>$40.00</td>
</tr>
<tr>
<td>Patient</td>
<td>N/A</td>
<td>N/A</td>
<td>$135.80</td>
</tr>
</tbody>
</table>
**Modifier 33**

**EXAMPLE Continued:**

- The GA modifier indicates that an ABN has been signed. Modifier 25 indicates that the E/M service was significant and separately identifiable and not part of the pelvic examination or collection of the Pap smear.
- The patient is not billed for her portion (i.e., deductible and co-pay for the problem visit) until Medicare has processed the claim. The diagnosis code for the patient’s problem, signs or symptoms should be linked to the E/M service (99213). The level of service for the E/M visit will depend on what was performed and documented.

**Modifier 33**

- For separately reported services specifically identified as preventative, the modifier should not be used. The most notable example of this is screening colonoscopy (CPT 45378), which results in a polypectomy (CPT 45388).
Modifier 33

Continued:

1. Services rated A or B by the US Preventive Services Task Force. These are posted annually on the Agency for Healthcare Research and Quality website at www.uspreventiveservicestaskforce.org/uspsfs/uspsabrecs.htm
2. Routine immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
3. Preventive care and screenings for children and newborn testing as supported by the Health Resources and Services Administration.
4. Preventive care and screenings for women as supported by the Health Resources and Services Administration.

Modifier 33 Example

• A 45 year-old male individual receives a cholesterol screening test, which is a recommended preventative service, during an office visit for hypertension management. The plan or issuer may impose cost-sharing requirements for the office visit because the recommended preventive service is billed as a separate charge and the office visit was not primarily for preventive services.
Modifier 24

*OIG Hit List

• Unrelated evaluation and management service by the same physician during a postoperative period.
  – The physician may need to indicate that an E/M service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier 24 to the appropriate level of E/M service.

• First Coast Service Options (FCSO) has discovered that the 24 modifier for E/M services, when billing within a global surgery period, has been billed incorrectly at least 60% of the time.
• The OIG has identified significant error rates associated with modifiers -25 and -59.
• OIG investigations revealed that 35% of claims allowed by Medicare with modifier -25 did not meet program requirements. This resulted in $538 million of improper payments. With regard to modifier -59, the OIG found that 40% of code pairs billed did not meet program requirements that a service must be demonstratively distinct from the other services performed that day. This resulted in an estimated $59 million of improper payments.
• The OIG has recommended that the CMS and its state contractors seek appropriate documentation for use of these modifiers and conduct prepayment and postpayment reviews to ensure their proper use.

Modifier 25

Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.
Modifier 25

• Translation: -25 lets you get paid for an office visit and a minor surgical procedure at the same time, done during the same visit.
• One example: An OB/GYN is doing a scheduled pelvic exam and finds polyps. Rather than schedule a second appointment, the OB/GYN takes a biopsy then and there.
• Note each word of the definition. The second service must be significant and quite separate from the first. Be sure to document carefully.

Cont. 25-

• DO NOT use this modifier with an E/M service that resulted in a decision to perform surgery. Reference (57) or possibly (59) instead.
Cont. 25-

- The phrase “patient’s condition required” is extremely important. In other words, it was medically necessary for the patient to have these extra services on the same day that another procedure or service was performed.

Improper Use of -25

- A patient visits the Physician on Monday with symptoms of GI bleeding. The Physician evaluates the patient and bills an E/M service. The Physician tells the patient to return on Wednesday for a sigmoidoscopy. On Wednesday, a sigmoidoscopy is performed in a routine manner.

- An E/M service (no modifier applied) may be billed for the service provided on Monday. However, a separate E/M service should not be reported for Wednesday when the patient returned for the scope procedure.
Modifier 59

- **Distinct Procedural Service:**
  The physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries).

Modifier 59 - Rationale

- The addition of this modifier to a procedure code indicates that the procedure represents a distinct procedure or service from others billed on the same date of service. In other words, this may represent a different session, different surgery, different anatomical site or organ system, separate incision/excision, different agent, different lesion, or different injury or area of injury (in extensive injuries).
Improper Use of -59

• It would be incorrect to unbundle CPT code 65775 corneal wedge resection for correction of surgically induced astigmatism with CPT code 66984 cataract extraction with IOL.
  – Coding for correction of surgically induced astigmatism is never coded at the time of cataract surgery.

Example

• When a recurrent incisional or ventral hernia requires repair, the appropriate recurrent incisional or ventral hernia repair code is billed. A code for initial incisional hernia repair is not billed in addition to the recurrent incisional or ventral hernia repair unless a medically necessary initial incisional hernia repair is performed at a different site. In this case, the “-59” modifier should be attached to the initial incisional hernia repair code.
Using Modifier 59 or Modifier 51

Many physicians perform two procedures during the same session and are confused about whether to report a modifier 59 (Distinct service) or modifier 51 (Multiple procedure). The differences between these modifiers are as follows:

**Modifier 59** indicates that:
- Two procedures have been performed during this session.
- The procedures are usually bundled under either CPT or Medicare rules.
- Both procedures can be reported in this specific case because they are distinct and unrelated to each other.
- The bundled procedure should be reimbursed in this case.

**Modifier 51** indicates that:
- Two procedures have been performed during this session.
- Two procedures are not bundled under either CPT or Medicare rules.
- Both procedures can be reported and should be reimbursed.

🌟 When using either modifier, the procedure with the lower relative value units will be reimbursed using the multiple procedure discount (usually 50%).
**Modifier 50**

- **Bilateral Procedure:**
  Unless otherwise identified in the same listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to appropriate 5 digit code.

**Modifier 51**

- **Multiple Procedures:**
  - Use this when doing multiple procedures - not E&M services – at the same session. Add the modifier to the second procedure (and to any thereafter) and Medicare and most other payers will reimburse you for them at a discounted rate.
  - Medicare has no interest in giving physicians an incentive to schedule patients multiple times to make sure they get paid for multiple procedures. On the other hand, it understands that multiple procedures mean greater efficiency – there is only one day in the OR, only one preoperative and postoperative period– so it doesn’t want to pay the full rate for each procedure. The compromise: Credit at a discount. Typically, payers reimburse at 100% of fee schedule for the first procedure, and 50% for the second through fifth and then 25% after that. List procedures in order of decreasing value for the best payment.
Modifier 51

Continued...

• There is some debate whether billing offices should bill for the full amount of the secondary procedures, or bill the discounted rate. We suggest billing the full rate so that you don’t risk having the payer discount an already discounted rate. Either way, track to make sure you are paid what you are owed.

Modifier 57

*Pre-op Modifier

• 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 of E/M service.
  - (90 day global)
  - This modifier is not to be used to report the treatment of a problem that requires a return trip to the operating room (See Modifier 78)
Modifier 52
• Reduced Services
• (Physician’s Discretion)

Modifier 53
• Discontinued Procedure
• (Beyond the Physician’s Control)

Using Modifier 52 or Modifier 53

**Modifier 52 (Reduced Services)** is used when:
• One procedure is attempted but was unsuccessful, an another procedure was then performed during the same surgical session; OR
• The physician did not perform all the components described in the code.
  – *Example:*
    - Attempted procedure- Dr. Smith attempted an endometrial biopsy (58100) but was unsuccessful because the patient had a stenotic cervix. He then performed a D&C (58120) during the same surgical session. He reported code 58120 plus 58100-52-51.

**Modifier 53** is used when:
• When the patient has undergone anesthesia induction and/or surgical prep but the planned procedure was not completed. No other procedure is performed during the surgical session. If a procedure is terminated after significant physician work, and another approach is then used to accomplish the surgery, report the successful surgery with a modifier 22 (increased procedural services) instead of a modifier 53.
Modifier 22

• (Increased Procedural Services)

is used when the services:

• Require more work than usual (e.g., extensive lysis of adhesions;
• Require more time to complete than ordinary;
• Require more physical and mental effort than normal; OR
• Severity of the patient’s condition makes it harder to complete (e.g.,
  patients who are morbidly obese)
• Include components that:
  – Are not normally part of the specific code as usually performed by
    the physician, and
  – Do not have another CPT code that describes them.

CONTINUED...
For when a service or procedure takes much longer or is
significantly more complicated than usual. Be sure to clearly
document how much longer the service or procedure took or
why it was complicated. Avoid using this modifier with codes
that use the word “simple” in their description. A simple
procedure is de facto not complicated. Similarly, make sure your
efforts exceeded the descriptions accompanying the CPT codes
for more complex procedures.
Modifier 58

• (Staged or Related Procedure or Service by the Same Physician During the Postoperative Period) is used when a procedure performed during the postoperative period was:
  • Planned or anticipated (staged);
  • More extensive than the original procedure; OR
  • For therapy following a surgical procedure.

Example:
Dr. Smith examined a patient with postmenopausal bleeding and a family history of ovarian cancer. A staged work-up and treatment is planned. She performed a dilation and curettage (58120). The pathology report revealed an endometrial carcinoma. The following day, she performed a radical abdominal hysterectomy, bilateral salpingo-oophorectomy and bilateral pelvic lymphadenectomy (58200). She reported codes 58120-0 and 58210-58.

Modifier 76

Repeat procedure or service by same physician or other qualified health care professional…
Modifier 77

Repeat procedure or service by another physician or other qualified health care professional…

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.
Modifier 32

Mandated Services: Services related to mandated Consultation and/or related services (e.g., third party Payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

Modifier 91

• Repeat Clinical Diagnostic Laboratory Test
  – In the course of treatment of the patient, it may be necessary to repeat the same lab test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure code and the addition of the modifier 91.
  – This modifier may not be used when other code(s) describe a series of test results. (e.g. glucose tolerance tests)
Modifier 80

Assistant surgeon...

(needless to say, $$ will go down)
Specific for Cardio

• LM – Left main coronary artery

• RI – Ramus intermedius coronary artery

Modifier AS

• Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant-at-surgery, non-team member.
  – Reimburses at the Non Physician practitioner rate of 85% of the Medicare Physician Fee Schedule, then Assistant at surgery rate of 16% of the calculated non physician practitioner rate.
• **Modifier CS**
  – Item or service related, in whole, or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico, including but not limited to subsequent clean-up activities.

• **Modifier AY**
  – Item or service furnished to an ESRD patient that is not for the treatment of ESRD.

• **Modifier GX**
  – Notice of liability issued, voluntary under payer policy
  – GX modifier must be submitted with non-covered charges only. This modifier differentiates from the required uses in conjunction with ABN.
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 three days.

- If the entity you’re coding for is not wholly owned or operated by a hospital, then you don’t need to append modifier PD (Diagnostic or related nondiagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days).

On the other hand, those entities (practices, etc.) that are wholly owned or operated by a hospital and that provide any diagnostic or related non-diagnostic services to a patient who is admitted to that hospital within three days must append modifier PD to the codes for those services. They must apply the modifier to relevant services as of July 1, 2012.

- Practices self-designate during Medicare enrollment whether they’re owned or operated as a hospital. The hospital is responsible for alerting the practices they own or operate if the patient is admitted.

- When practices append PD to a code that doesn’t have both professional and technical components, Medicare will pay for the service based on the facility rate (rather than the non-facility rate). If a code has both professional and technical components, modifier PD will trigger Medicare to pay the practice for only the professional component.
**Modifier NB**

- Nebulizer system, any type, FDA cleared for use with specific drug

**Modifier PT**

- Colon cancer screening test; converted to diagnostic test or procedure
- Assign this modifier with the appropriate CPT procedure code for colonoscopy, flexible sigmoidoscopy, or barium enema when the service is initiated as a colon cancer screening service but then becomes a diagnostic service.
**Modifier AI**

- Principal physician of record
- Must amend if you are the attending
- Effective January 1, 2010, Medicare does not pay for codes 99241–99242 and 99251–99255. Providers will use Office or Other Outpatient Services 99201-99205 for new patients and 99212-99215 for established patients. Codes should be selected by patient type and documentation guidelines.

**Modifier AI**

- If CMS cannot determine who the attending physician was in a particular case, all parties involved will have their claims denied.

- See the MLN Matters article MM6740 for more information:
Claims with G Modifiers

- The OIG will be reviewing possible errors in instances when providers expected denials. When a provider obtains an ABN, modifier GA Waiver of liability statement issued as required by payer policy of modifier GX Notice of liability issued, voluntary under payer policy (depending on whether the ABN was required or voluntary) is appended to the procedure code.

Claims with G Modifiers

- In other instances, payments are not expected, and modifiers 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 of GZ Item or service is expected to be denied as not reasonable and necessary is used. In those instances, the OIG has concerns contractors have made payments inappropriately. A previous review showed that $4 million in inappropriate payments were made on claims with modifiers GA and GZ appended.
Modifier GA

- Indicates that a required ABN form has been signed and is on file.

- Must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary, and that they do have an ABN signed by the beneficiary on file.

Modifier GZ

- Indicates that an ABN form has not been signed.

- Must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary, and that they do not have an ABN signed by the beneficiary.
Modifier GX

• Indicates that a voluntary ABN has been signed for a non-covered service.

• Modifier GX may be reported for services formerly reported with the Notice of Exclusion from Medicare Benefits (NEMB) form.

• The NEMB form has been discontinued.

Modifier GY

• Indicates that the service provided is not a covered Medicare benefit.

• The service is being reported to Medicare in order to receive a denial.
## Modifier AT

- Acute treatment

- *Example:* Patient has Tetanus injection due to an injury. Some contractors want the “AT” modifier added to tell the story better.

## Modifier TC

- Technical component. Under certain circumstances, a charge may be made for the technical component alone. These are institutional charges and not billed separately by physicians. Portable X-ray suppliers only bill for the technical component and should utilize the TC modifier.
**Modifier Q0**

- Investigational clinical service provided in a clinical research study that is an approved clinical research study
  - (ICD’s primary prevention)

**Modifiers RC and LC**

- **Modifier RC**
  - Right Coronary Artery

- **Modifier LC**
  - Left circumflex coronary artery
  - *Note... (LD) Left anterior descending coronary artery....*
With the implementation of ICD-10 in 2015, more specific anatomical sites, HCPCS modifiers will not be needed.

Finally, don’t fall into the trap of assuming that because you’re getting reimbursed, you must be using modifiers appropriately. Unfortunately, the fact that the payer made payment doesn’t mean that it was paid appropriately.
Tips, Tools, and Techniques

• Be sure to reference book, chapter, verse when it comes to modifier usage. (example; CPT Appendix E which gives CPT codes that are Exempt from Modifier 51)

• Utilize a claim scrubber if possible for verification

• Ask important questions such as “What do I need to change-up about a code/procedure”?

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Questions?

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