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Meet the Presenter…

On the topic:
Correct Coding with Modifiers

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Correct Coding with Modifiers

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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.”

Modifiers...

- Are essential tools for coding.
- Are necessary to effectively communicate between providers and payers.
- Do not ensure reimbursement.
  - Some payers do not recognize or accept modifiers.
- Impact your revenue dollars.
  - Many claims are rejected and/or denied because of the use of, or lack of a modifier.
CPT Modifiers

HCPCS Modifiers

• HCPCS Level I (CPT) Modifiers
  – Two-digit numeric and/or alphanumeric designations
    • Explain to an insurance carrier a change in the description of
      the code without changing its meaning
    • Example: Physical status modifiers in anesthesia
  – American Medical Association (AMA)
    • Responsible for development and updates
  – CPT Editorial Panel
    • Determines definition and guidelines for CPT modifier use
  – Listing found in Appendix A of the CPT code manual
**Modifier 33**

- **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 this service.

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

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**Modifier 33**

- **Modifier 33 – Preventive Service**
  - An informational modifier adopted in 2011 in response to The Patient Protection and Affordable Care Act (PPACA), which requires all health care insurance plans to cover preventive services and immunizations without any cost-sharing (i.e., co-pays, coinsurance, or deductibles).

  - Modifier 33 was created to allow providers to identify to insurance payers that the service was preventive under applicable laws, and that patient cost-sharing does not apply.
Modifier 33

- When these services are part of an office visit, the office visit may not have cost-sharing if the primary reason for the visit is to receive preventive services.

- Cost-sharing is, however, permitted for an office visit when the office visit and covered preventive services are billed separately, and the primary purpose of the office visit is not delivery of the covered preventive services.

Modifier 33

- Modifier 33 is applicable for the identification of preventive services without cost-sharing in these four categories:
  
  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.
  
  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

- The most updated instruction regarding the use of Modifier 33 are available on the Centers for Medicare and Medicaid Services’ (CMS) website at:


  *Website addresses are subject to change.

Surgical Modifiers

- Every surgical procedure has a *global period*:
  - 0-90 days, defined by each carrier individually
  - Includes:
    - Preoperative management
    - Surgical procedure
    - Certain types of anesthesia
    - All typical follow-up care
Surgical Modifiers

• For required care related to the surgery during postoperative period
  – Provider cannot bill additional charges.

• For a service or procedure by the same practitioner or group unrelated or significantly separately identifiable
  – A modifier indicates that the service was not included in the initial procedure and/or service.

Modifier 25

• Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service.
**Modifier 25**

- Modifier 25 used to indicate:
  - That on the day a procedure or service was performed, the patient’s condition required a *significant, separately identifiable* E/M service.
  - E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided
  - Different diagnosis not required for reporting of the E/M service
  - Documentation must support the E/M level selected.

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**Modifier 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.

*Website resource:*

Modifier 25

• Questions for determining if work goes above and beyond usual pre- and postoperative work:
  – Is the work more than the usual preoperative and postoperative work?
  – Does the complaint or problem stand alone as a billable service?
  – Did the provider perform and document the key components of an E/M service for the complaint or problem?
  – Is there a different diagnosis for the significant portion of the visit? If not, was the extra work more than the usual?

Modifier 25

• Appropriate Usage
  – The E/M service is performed by the same physician on the day of a minor surgical procedure.
    • A minor surgical procedure (as defined in this policy) has a 0-day or 10-day postoperative period.
  – The E/M service is beyond the usual pre-operative and postoperative care associated with the procedure or other service.
  – The problem-focused E/M service is performed at the same time as a preventive care visit.
  – The E/M service is reported with preoperative critical care codes within a global surgical period.
**Modifier 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.
  - If the E/M service is performed on a different day than the procedure.
  - For an E/M service within the usual pre-operative or postoperative care associated with the procedure.
  - When the reason for the visit was strictly for the minor procedure since reimbursement for the procedure includes the related pre-service work.

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**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.
  - Allows separate payment for that visit at which the decision to perform the surgery was made:
    - If adequate documentation is available demonstrating that the decision for surgery was made during a specific visit
    - 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 58**

- **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.

**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 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). Medicare and most other payers will reimburse the subsequent service(s) at a reduced 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.

• Modifier 51 should not be appended to designated add-on codes.

• 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 51 Example:
  – Same Operation, Different Site
    • When the same procedure is performed on different sites.
    • A patient has an excision of a 1.5 cm benign lesion from the forearm & at the same time has an excision of a 3 cm benign lesion from the neck.
Modifier 59

• Distinct Procedural Service:
The physician or other qualified health care professional 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).

Use only when no other already established, appropriate modifier is available.

Modifier 59

• Modifier 59 has been used for a variety of circumstances, including to identify different encounters, anatomic sites and distinct services, making it the highest utilized HCPCS modifier.

• Because it can be used to bypass National Correct Coding Initiative edits, it is also associated with abuse leading to audits.
National Correct Coding Initiative (NCCI)

- Developed by CMS to prevent improper payment when incorrect code combinations are reported; contains two tables of edits:
  - 1. The Column One/Column Two Correct Coding Edits table
  - 2. The Mutually Exclusive Edits table
- Include code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual.
- Modifier indicators in the NCCI:
  - “0” Associated modifier cannot be used to bypass the edit
  - “1” Associated modifier may be used to bypass the edit if it meets the criteria under appropriate circumstances
  - “9” Edit deleted on the same date as when it became effective.

Website resource: [https://www.cms.gov/nationalcorrectcodinginitiative](https://www.cms.gov/nationalcorrectcodinginitiative)

NCCI Guidelines: Modifier 59

- Was established for use when several procedures are performed on different anatomical sites, or at different sessions (on the same day)
- Indicates that the procedure represents a distinct service from others reported on the same date of service
- Is appended when distinct and separate multiple services are provided to a patient on a single date of service
- Was developed explicitly for the purpose of identifying services not typically performed together
- Claim submitted with modifier 59 should include clear documentation of separate, distinct procedure
New for 2015

- To create more precise coding options and reduce errors, CMS created four new HCPCS modifiers to define subsets of the -59 modifier.

1. **XE** (Separate encounter) A service that is distinct because it occurred during a separate encounter.

2. **XS** (Separate structure) A service that is distinct because it was performed on a separate organ/structure.

3. **XP** (Separate practitioner) A service that is distinct because it was performed by a different practitioner.

Subset Modifiers

4. **XU** (Unusual non-overlapping service) The use of a service that is distinct because it does not overlap usual components of the main service.

- NOTE - these modifiers do not replace 59. CMS may request that 59 not be used when a more descriptive modifier is available.

Using Modifier 59 or Modifier 51

• Many providers 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.

Using Modifier 59 or 51

• **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.
HCPCS Modifiers

- **HCPCS Level II (HCPCS Modifiers)**
  - Developed by the Centers for Medicare and Medicaid Services (CMS)
  - Intended for use in the Medicare and other insurance programs to ensure consistent claims processing
  - Used when information provided by code descriptor needs to be supplemented to identify special or unusual circumstances
  - Alphanumeric or two letters
  - Accepted by many carriers
  - Data set updated and published yearly
  - Complete list found in the HCPCS manual
Modifier AI

• Principal physician of record
• Must amend if you are the attending
• Medicare does not pay for codes 99241–99242 and 99251–99255 (effective January 1, 2010.)
  • Providers must 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 MLN Matters article MM6740 for more information:

*Website addresses are subject to change.
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.
  – The most notable example of this is screening colonoscopy (CPT 45378), which results in a polypectomy (CPT 45383).
Modifiers 54, 55, and 56

- Modifier 54 – Surgical Care Only
  - One physician or other QHCP performed the surgical procedure and another provided preoperative and/or postoperative management, surgical services may be identified by adding the modifier 54 to the usual procedure number.

- Modifier 55 – Postoperative Management Only
  - One physician or other QHCP performed postoperative management and another the surgical procedure, the postoperative component may be identified by adding the modifier 55 to the usual procedure number.

- Modifier 56 – Preoperative Management Only
  - One physician or other QHCP performed the preoperative care and evaluation and another the surgical procedure, the preoperative component may be identified by adding the modifier 56 to the usual procedure number.

Modifiers 54, 55, and 56

- When providing less than the full global package:
  - More than one physician or other QHCP provides services included in the global package, e.g., one performed surgery, another provided follow-up
  - Payment for postoperative, post discharge care split between two or more physicians or other QHCP when they agree on the transfer of care
  - Sum of the amount approved for all physicians or other QHCP may not exceed approved amount if one physician or other QHCP provided all services
  - **Exception**: surgeon performed only surgery, another physician or other QHCP provided preoperative and postoperative inpatient care; results in payment higher than the global allowed amount.
Claims with G Modifiers

- The OIG analyzed all Part B claims with GA, GZ, GX, or GY modifiers from 2011 and found that there were “...vulnerabilities in how Medicare pays for these claims...” resulting in improper payments of claims submitted with G modifiers.

- While we commonly associate G modifiers with services that are going to be denied by Medicare, the use of a G modifier does not always result in an automatic denial.

Source: [http://oig.hhs.gov/oei/reports/oei-02-10-00160.pdf](http://oig.hhs.gov/oei/reports/oei-02-10-00160.pdf)

Claims with G Modifiers

- **Modifier GA**
  - 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 (before service is provided) by the beneficiary on file.

- **Modifier GY**
  - Indicates that the service provided is not a covered Medicare benefit.
  - Appended to procedure or service code when the patient wants the claim submitted to Medicare in order to receive a denial.
Claims with G Modifiers

• 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.
  
  – GX modifier must be submitted with non-covered charges only. This modifier differentiates from the required uses in conjunction with ABN.

Claims with G Modifiers

• 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.
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Questions?

• Thank you for your attendance!

• Get your questions answered on PMI's Discussion Forum: http://www.pmimd.com/pmiForums/rules.asp

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