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Meet the Presenter…

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On the topic:
Effective Use of Modifiers
The Importance Of Modifiers

- CPT Modifiers
- HCPC Modifiers
- Medicare Modifiers
- Improper use of modifiers can cost your practice denied claims and lost revenue.
- Certified Coders have over 120 hours of formal training in coding and documentation guidelines.
Modifiers

- We will not cover every modifier in this presentation. There are numerous specialty-specific modifiers as well as Medicare Modifiers.

Modifiers, Medicare

- There are numerous Medicare modifiers such as GA, GX, GY and GZ.
- Ambulance modifiers (QN and others)
- Anesthesia Physical status modifiers (P1 to P6)
- Erythropoiesis stimulating agents modifiers (EA, EB and EC) (for renal failure, chemo, and HIV patients)
- Modifiers for DME-MAC claims (KX)
- PQRS modifiers 1P, 2P, 3P and 8P
- Q modifiers, Q0 to Q6, Class findings Q7, Q8 and Q9, and additional Q codes.
If Medicare guidelines disagree with AMA CPT guidelines, who do you go with?
Anatomy of a Coding Question

What do we need to know?

- Need specific carrier and state
- Need ICD-10 linking code
- What other codes were reported on the same DOS?
- Need modifier if applicable; need to know if this carrier has documented requirements.
- Is there a Medicare Local Coverage Determination (LCD) on this topic?
- Need any documentation guidelines on this procedure.
- Is this a carrier-specific rule?
- Is it worth appealing?

Modifiers

Introduction

The primary purpose of modifiers is to denote circumstances which affect the performance of a procedure or service. They are also used to provide supportive information, such as a second surgical opinion provided at the request of a professional review organization.

Always code a CPT numeric modifier before an alpha modifier (HCPCS).
A physician performs a procedure bilaterally, and the procedure is listed in CPT as unilateral.

A normally simple procedure becomes unusually complicated because the patient suffers from diabetes.

Modifiers

Methods of Reporting

1. The most commonly accepted method is to list modifiers next to the CPT or HCPCS code on the same line of the claim form.

2. A second method of reporting modifiers is to repeat the code on subsequent lines of the claim form with one modifier next to each of the repeated codes.
Increased Procedural Services

Denotes circumstances for which a procedure or service required more time, resources and effort than usual. A special report is required.

The 50 year old patient had surgical repair of a recurrent, inguinal hernia (reducible). Use of the unusual services modifier is appropriate with the surgery for the operation was very difficult and required additional time and effort to perform because the patient was morbidly obese.

Modifier - 22

Increased Procedural Services

Denotes circumstances for which a procedure or service required a substantially greater than typically required. A special report is often required.

The 50 year old patient had surgical repair of a detached retina (67107) because this was an automobile accident and there was both swelling and brain trauma the surgery took longer than usual.
Modifiers

- 23 Unusual Anesthesia

General anesthesia is given when normally either a local or no anesthesia is provided.

Performing a cystourethroscopy on a three-year-old child would likely require general anesthesia, whereas the same procedure on an adult would not.

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

Allows the physician to report an E & M service was performed during a postoperative or global period for a reason(s) unrelated to the original procedure.

A patient who is being followed by her gynecologist during a pregnancy comes in for an additional visit because she has developed acute bronchitis. The bronchitis is unrelated to the pregnancy and necessitated an additional visit over and above her regular pregnancy check-ups. The E/M code for the visit is billed to the insurance carrier with a -24 modifier linked to Acute Bronchitis.
Modifiers

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

Indicates that on a day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E&M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed.

A patient is seen in the office for evaluation of his COPD, coronary artery disease and diabetes. He is also complaining of swelling in his left knee which developed after he fell while getting out of his car. The physician performs an expanded, problem-focused history and examination of his chronic illnesses along with his knee and performs a joint aspiration of the left knee.

Modifiers

- 26 Professional Component

Refers to the physician’s time, skill, and judgment in interpreting the results of tests and procedures.

If an x-ray of a patient’s chest is taken in a physician’s office and is sent to a radiologist for reading and interpretation, the radiologist would report his service using modifier 26.
**Modifier - 26**

- 26 Professional Component

Refers to the physician's time, skill, and judgment in interpreting the results of tests and procedures. Example: 92133 GDX.

The GDX was performed by another clinic and billed as 92133-TC-RT. The physician performing the interpretation and report with 92133-26-RT.

The Technical Component is reported with MOD-TC

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**Modifiers**

- 27 Multiple Outpatient Hospital E/M Encounters on the Same Date

Provides for reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic) on the same day.
Modifiers

- 32  Mandated Services

Those requested by an insurance carrier, peer review organization, utilization review panel, HMO, PPO or other entity.

An extended additional opinion consultation would be reported as: 99214-32. The -32 modifier is used to alert the payer's claim processors that the service was mandated and should receive special handling.

Modifiers

Modifier 33: Preventive services

Use Modifier 33 with codes for services that could be either preventive or diagnostic, to identify that the service rendered or ordered was for preventive health purposes.

- 88141 – Cytopathology, cervical or vaginal
- 45378 – Colonoscopy
- 80061 – Lipid panel
- 77080 – Dual energy X-ray absorptiometry, bone density study
- 97802 – Medical nutrition therapy
Modifier 33

Do not use modifier 33 when the service is already specifically identified as preventive within the definition. Examples:

- 99395 – Periodic comprehensive preventive medicine E&M
- 77057 – Screening mammography, bilateral
- 92551 – Screening test, pure tone air only
- 99412 – Preventive medicine counseling and/or risk factor reduction intervention(s)
- G0102 – Prostate cancer screening

Modifiers

-47 Anesthesia by Surgeon

When the surgeon is required to provide the general anesthesia services normally handled by an anesthesiologist. Used in rural areas.

Suppose the surgeon removed a ruptured appendix from a patient and also provided a general anesthetic. The surgeon would add the modifier –47.
Modifiers
- 50 Bilateral Procedures

Procedures are assumed to be unilateral unless they are either always performed bilaterally or are otherwise noted in CPT.

An Otoplasty is performed on a patient's left and right ears.

Some carriers require the procedure reported using modifier -50 and placing a “2” in the Units column. This is very rare and carrier-specific.
Modifiers

- 51 Multiple Procedures

Used to identify multiple surgical procedures performed on a patient during the same operative session.

The repair of a simple neck wound and the closed treatment of a clavicle fracture would be coded as follows:

Note that the higher charge procedure (fracture treatment in this case) is listed first and the multiple procedure modifier is added to the lesser or secondary service. If three procedures had been performed, the services would be ranked from highest to lowest charge on the claim form and the "-51" modifier would be added to all but the first (highest charge) procedure.

- 52 Reduced Service

Signifies that a procedure was reduced or eliminated in part.

The physician removes a coccygeal pressure ulcer and performs a coccygectomy but does not use a primary suture or skin flap closure. (The physician wants to continue cleansing the wound for a period of time before closing.) The proper way to report the procedure would be as follows.

At a later date the physician would code for the appropriate wound closure procedure.
**Modifier - 52**

**52 Reduced Service**

Signifies that a procedure was reduced or eliminated in part. Use for all bilateral procedures performed on one eye.

The physician performs Fundus Photography (92250) on a person with one good eye (Left Eye). Since this is a bilateral procedure, append MOD-52 and MOD-LT.

**Modifier 53**

**53 Discontinued Procedure**

Indicates that the physician elected to terminate a surgical or diagnostic procedure because of extenuating or threatening circumstances.

Dr. Bob Jones has to terminate the operation, coronary artery bypass, vein only, two coronary venous grafts, due to the patient's declining vital signs. The patient is moved to intensive care for observation.
Listed surgical procedures in the CPT book include the following components that make up the surgical package.

- **Pre-operative Care**
  - MOD-56

- **Operation**
  - MOD-54

- **Normal Follow-up Care**
  - MOD-55

The Surgical Package

**Major surgery package with 90-day Post-op:**

This includes:
- One pre-operative visit, pre-op period starts the day *before* surgery.
- 90 days of follow-up starting the day *after* surgery.
The Surgical Package

Operation Surgical Package Included

Services:

- Dressing changes;
- Local incisional care;
- Removal of operative pack;
- Removal of cutaneous *sutures and staples*, lines, wires, *tubes, plugs*, drains, casts, and splints;
- Insertion/irrigation/removal urinary caths;
- Peripheral intravenous lines;
- Nasogastric & rectal tubes;
- Changes/removal tracheostomy

Modifiers

- 54 Surgical Care Only
- 55 Post-operative Management Only
- 56 Preoperative Management Only

Used when a physician only performs a portion of the surgical package.

The surgery is performed in Florida (winter home) and the post-op back in Albany NY. Another physician manages the operative follow-up. [Excision or curettage of bone cyst]
Modifiers

-54 Surgical Care Only
-55 Post-operative Management Only
-56 Preoperative Management Only

Used when a physician only performs a portion of the surgical package.

Physician B in Albany performed the follow-up care.

Modifiers 54, 55 & 56

-54 Surgical Care Only
-55 Post-operative Management Only
-56 Preoperative Management Only

Used when a physician only performs a portion of the surgical package. Be sure to follow your carriers instructions for Box 19 for post-op care.

Physician B performed the follow-up care for cataract surgery on the left eye. This is often called Co-Management.
**Modifier 57**

- **57 Decision for Surgery**

Identifies an evaluation and management service that results in the initial decision to perform surgery.

A patient presents to the emergency department complaining of acute lower abdominal pain. She is evaluated by a general surgeon who determines that she has a ruptured appendix. He immediately transfers her to the operating suite and performs an appendectomy. The services would be coded as follows:

1. **99284-57**
2. **44960**

**Modifier 58**

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

There are three ways to use modifier –58:

1. For a surgery result planned in stages – a staged procedure.

This Code would be used for "urethroplasty for second stage hypospadias repair; less than 3 cm" if this second stage was performed during the postoperative period of the first procedure.
Modifiers

- **-58** Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

2. To report a more extensive procedure performed during the postoperative period of a less extensive procedure.

This code would be used for "repair of hypospadias cripple requiring extensive dissection" if the procedure was performed during the postoperative period of 54308 on the previous slide.

3. To report a therapy given after a diagnostic surgical procedure.

29870 "diagnostic knee arthroscopy", carries a 90-day global period. If a claim is reported under the same surgeon's name for physical therapy during the 90-day postoperative period, 97124-58 should be reported for the massage therapy.
Modifiers

- 59 Distinct Procedural Service

Allows the physician to indicate that a procedure or service was distinct or independent from other services performed on the same day.

On Monday, a dermatologist performs a biopsy on the face. On Thursday, following the results of the biopsy, he removes the 2 cm malignant lesion and does another biopsy of a different site on the face. The services performed on Thursday are reported as follows:

2015 Modifier Updates (X{EPSU})

- **NMLN Network MM8863**: Specific Modifiers for Distinct Procedural Services. Effective Date is January 1 2015.
- **Modifier -59**, the most widely used HCPCS modifier, indicates that a code represents a service that is separate and distinct from another service with which it would usually be considered to be bundled.
- **CMS will continue to recognize the -59 modifier**, but notes that CPT instructions state that the -59 modifier should not be used when a more descriptive modifier is available. While CMS will continue to recognize the -59 modifier in many instances, it may selectively require a more specific - X{EPSU} modifier for billing certain codes at high risk for incorrect billing.

“X*” HCPC modifiers

• CR8863 provides that CMS is establishing the following four new HCPCS modifiers (referred to collectively as -X{EPSU} modifiers) to define specific subsets of the -59 modifier:
  
  • -XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
  • -XS Separate Structure, a service that is distinct because it was performed on a separate organ/structure

• -XP Separate Practitioner, a service that is distinct because it was performed by a different practitioner
• -XU Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service.
**Modifier 62**

- **62 Two Surgeons**

Reported when two physicians are acting as co-surgeons. Each surgeon is acting as a “primary” surgeon performing a different aspect of a complex procedure.

A laminectomy is performed jointly by a neurosurgeon and an orthopedic surgeon. Each physician might list the following on his/her claim:

- Third party payers often allow sixty percent of their prevailing fee to each surgeon in such cases.

**Modifier 66**

- **66 Surgical Team**

Complex surgical procedures require the skills of more than two surgeons.

A heart-lung transplant with recipient cardiectomy/pneumonectomy is performed. Each surgeon would report the procedure as shown.
Multiple Surgeon Indicators

The Indicators for multiple surgeons and co-surgeons are in the Medicare PFSRVU database. These are available on the Medicare (RVU lookup) website and specialty manuals. The flag or indicator specifies whether multiple surgeons are allowed for a specific CPT code.

Modifiers

- 73 Discontinued Out-Patient Hospital/Ambulatory Surgery Center Procedure Prior to the Administration of Anesthesia
- 74 Discontinued Out-Patient Hospital/Ambulatory Surgery Center Procedure After Administration of Anesthesia

These two modifiers delineate the instance where the intended procedure was not able to be completed and was discontinued.
Modifiers

- 76 Repeat Procedure By Same Physician
- 77 Repeat Procedure By Another Physician

These two modifiers are to be used when the procedure has been repeated subsequent to the original service.

A patient is brought to the hospital with internal hemorrhaging which is repaired surgically using anoscopy. Three days after surgery, the patient begins hemorrhaging again and the surgeon must perform the same repair again. If the same procedure code was being reported and the same physician performs the second repair, he/she would use the -76 modifier.

Modifier 78

- 78 Return to the Operating Room for a Related Procedure During the Postoperative Period

Reports related procedures performed in the operating room within the assigned postoperative period of a surgical procedure.

A patient's operative site bleeds after an initial surgery and requires a return to the operating room to stop the bleeding, the same procedure is not repeated. Thus a different code, 35860, exploration for postoperative hemorrhage, thrombosis or infection; extremity, would be reported with the -78 modifier appended.
**Modifier - 78**

- 78 Return to the Operating Room for a Related Procedure During the Postoperative Period

Reports related procedures performed in the operating room within the assigned postoperative period of a surgical procedure.

Use 67108-78, Repair of retinal detachment, w/ vitrectomy . . . vs 67112, Repair of retinal detachment, w/ scleral buckling or vitrectomy. . . The first operation was the same procedure.

**Modifier 79**

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

Notifies payers that the procedure was performed during the postoperative period of another procedure but is not related to that surgery.

A patient has a femoral-popliteal graft (35556) and goes home. The incision and graft heal well. However, the patient develops acute renal failure a week after being home and is hospitalized. The patient does not respond to medical treatment of the renal failure. Hemodialysis is indicated, and the physician inserts a cannula for hemodialysis (36810).
Modifier - 79

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

Notifies payers that the procedure was performed during the postoperative period of another procedure but is not related to that surgery.

A patient has the second cataract removed during the global period of the first eye. Note: Three (3) Modifiers.

Modifiers 80, 81 and 82

- 80    Assistant Surgeon
- 81    Minimum Assistant Surgeon
- 82    Assistant Surgeon (Where Qualified Resident Not Available)

Used when one physician assists another physician in performing a procedure.

To report a closure of intestinal cutaneous fistula, the primary operating surgeon reports code 44640, and the assistant surgeon reports 44640-80.
**Modifier 90**

- **90 Reference (Outside) Laboratory**

When the physician bills the patient for lab work that was performed by an outside (or “reference”) lab.

An internist orders a complete blood count. He does not perform in-office lab testing. He has an arrangement with a laboratory to bill him for the testing procedure, and, in turn, he bills the patient. The physician's staff performs the venipuncture. (allergy testing)

**Modifier 91**

- **91 Repeat Clinical Diagnostic Laboratory Test**

Used when necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results.

This modifier may not be used when tests are rerun to confirm initial results due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required.

This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance).
- 99 Multiple Modifiers

Can be added to alert the carrier to the fact that two or more modifiers are associated with the procedure.

Modifiers and Interpretation

• There is and will always be some interpretation among certified coders, auditors and consultants concerning modifiers—particularly 25 and 59 (and the new X modifiers).
• You will only know if you are using them incorrectly when you are audited. You may be paid on MOD-25 but that does not mean you are compliant.
• Proper use of modifiers will increase your reimbursement but it must also be compliant.
• Not every carrier will audit modifiers the same.
HCPCS and Modifiers

HCPCS stands for Healthcare Common Procedural Coding System.

It was developed in 1983 by the Health Care Financing Administration.

HCPCS codes are updated and published annually by CMS.

HCPCS is pronounced HIC-PICS.

HCPCS Overview

HCPCS codes were created because CPT describes only physicians' procedures and services and CMS needed another method to code for supplies, injections, and other procedures and services it recognizes that either were not found in CPT or were not extensively coded.

CPT Code: 99070 Supplies

HCPCS Codes: A4580 cast supplies
HCPCS Codes: C1781 mesh
HCPCS Anatomical Modifiers

HCPCS Modifiers -RT & -LT

When coding procedures on either the left or right eye use the appropriate HCPCS modifier:

LEFT EYE - MOD-LT
RIGHT EYE - MOD-RT.

Note that some carriers may require MOD-50 in lieu of the –RT and –LT modifiers.

Toes

- Use the HCPCS modifiers to indicate the specific finger or toe:
  - TA: left foot great toe
  - T1-T4: left foot digits 2–5
  - T5: right foot, great toe
  - T6-T9: right foot digits 2-5
**Fingers**

- FA: Left hand, thumb
- F1-F4: left hand, digits 2-5
- F5: right hand, thumb
- F6-F9: right hand digits 2-5

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**HCPCS Anatomical Modifiers**

**HCPCS Eyelid Modifiers**

*When coding procedures on the eyelids, use the appropriate HCPCS modifier:*

Eyelid Modifiers (e.g., punctal plugs and epilation.)

- E1: Upper left, eyelid
- E2: Lower left, eyelid
- E3: Upper right, eyelid
- E4: Lower right, eyelid

Note: Epilation is most often reported with RT/LT. You will need to match these the laterality code in ICD-10.
This is the Technical Component Modifier. This includes the ownership of the equipment and the technician’s time.

The following codes require special reporting. They both have a bilateral technical component and a unilateral professional component.

76519-TC Ophthalmic Biometry Codes w/ IOL power Calculation

92136-TC Optical Coherence Biometry (OCB)

Bilateral Technical Component / Unilateral Professional Component

Report this code (and 92136) as three separate lines:

76519-TC
76519-26-RT
76519-26-LT

The TC applies to both eyes inherently, whereas each eye must be specified for the professional component.

I call this example a perfect medical coding trivia question.
Modifiers

• 2016 OPPS final rule introduces new modifiers and restructured APCs.

• New modifiers
  • CP: Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification (c-APC) procedure, but reported on a different claim.
  • CT: Computed tomography (CT) services furnished using equipment that does not meet each of the attributes of the national electrical manufacturers association (nema) xr-29-2013 standard

HCPCS Anatomical Modifiers

What is the order of Modifiers?

• Always list the number (MOD-25 or MOD-59) before an anatomical modifier (LT/RT or E1 – E4)
• Always list a modifier that impacts reimbursement (MOD-25 or MOD-59) before information only modifiers (MOD-32 or MOD-57)
• Mod-51 would be after MOD-25 or MOD-59.
Sources for Information

- Medicare LCD or carrier bulletin
- AMA CPT™ Assistant Archives
- Specialty publications
- Medical Associations
- Be wary of advice from another provider during a national convention. Their rules may not be the same as your local rules!

Summary

- Learn the basics.
- Study your modifiers.
- Know which ones can impact reimbursement.
- Be sure to train all providers on proper modifier use.
- Remember that there are gray areas and different interpretations of some modifiers.
- Track carrier-specific rules that impact modifier usage. Use your sources.
Modifiers Examples
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