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On the topic:

Modifiers That Raise Red Flags

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Modifiers That Raise Red Flags

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What Are Modifiers?

Modifiers alter the meaning of a code description but has not changed in its overall definition.

- E/M modifiers
- Surgery or Procedure modifiers
- Lab or Medicine modifiers
- Modifiers that are informative only
- Modifiers that affect payment

Did you know there's an order for modifiers? Modifiers that affect payment, unless otherwise instructed by a specific payer policy, should always be first listed.
Codes Have Requirements

Every HCPCS code has performance and documentation requirements.
- Level 1 (CPT codes)
- Level 2 (National codes)

Example:
20552 Trigger point injection (single or multiple) (1 or 2 muscle groups)
- Pre-surgical evaluation (day of)
- Consent
- Aseptic preparation
- Performance of the procedure
- Needles
- Anesthetic
- Gauze, dressings, bandages
- Post-procedure instructions

Global Surgical Package

Are there 90 or 92 postop days for major surgery?

To apply the right modifiers at the right time – you need to understand the global surgical package.
Global Surgical Package

CPT Guidelines

- Local infiltration, MCP/MTP/Digital blocks, topical anesthesia.
- After the decision for surgery, one related EM service the date immediately prior to or on the date of the procedure (H&P)
- Immediate post-op care, dictating notes, talking with family or other physicians/QHPs, writing orders
- Evaluating the patient in post-anesthesia recovery
- Typical postoperative follow-up care.

CMS Guidelines

- Pre-operative visits after the decision to operate is made.
- Intra-operative services that are normally a usual and necessary part of the procedure.
- All additional medical or surgical services required during the postoperative period of the surgery because of complications, not requiring a return trip to the OR.
- F/up visits during the postoperative period that are related to recovery from the surgery.
- Post-surgical pain management
- Supplies, except those identified as exclusions
- Dressing changes, local incision care, suture removal, staples, drains, lines, wires, tubes, casts, splints or insertion of routine IVs, tubes, irrigation, etc.

Global Surgical Package

Private Payers...

- Follow Medicare guidelines
- Develop their own guidelines
- Have a mix of Medicare and their own

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Payer Policy Determines Rules

Medicare, the CPT codebook, and most payer guidelines agree that the following guidelines apply to 0, 10, and 90-day global periods.

0 days
- Zero pre-op period.
- Zero post-op period.
- EM performed the day of the procedure is not payable

10 days
- Zero pre-op period.
- EM performed the day of the procedure is not payable.
- The global period is actually 11 days (procedure day + 10 days)

90 days
- EM performed day before or day of surgery included
- Total Global is 92 days (1 day prior to surgery, day of surgery and 90 days following)

Global Surgical Package

Code 30300 carries a global period of 10 days.

Established patient seen today in the office with complaints of a FB lodged high up in the right nostril. Examination revealed small toy lodged in the upper right naris. The provider removed the object with forceps and checked the patient for injury and infection.

- Pre-service work 18th
- Procedure 18th
- Postoperative care 18th-28th

New charges can begin again on the 29th
Modifier 22 Increased Procedural Service

Novitas

When work to provide a service is substantially greater than typically required. Documentation must support the substantial additional work and reason for it such as:

- Increased intensity
- Time
- Technical difficulty
- Severity of patient’s condition
- Required physical and mental effort

Only apply to procedures with a 0, 10, or 90 day surgical package. Do NOT apply to E/M services.

Noridian

Documentation to indicate that the work performed to provide the service was substantially greater than typically required.

- Must support the substantial additional work
- Reason for additional work
  - Increased intensity
  - Time
  - Technical difficulty
  - Severity of patient’s condition
  - Physical and mental effort required

- Documentation includes paragraph titled Unusual Procedure
- Should not be appended to an E/M code

Correct Use:
- Only apply to 0, 10, or 90 day global period procedures
- Clearly indicate the difficulty of the procedure beyond the norm
- Submit explanation with the claim (box 19)

Incorrect Use:
Do not use generalized statements like “it took 2 hrs,” “the patient was obese,” or “this was a difficult surgery.”
Modifier 22 Increased Procedural Service

United HealthCare Community

In order to be considered for additional reimbursement...
A separate document containing a concise statement about how the service differed from the usual service or procedure is required

Documents must indicate:
- substantial additional work performed
  - reason for the additional work (including but not limited to)
  - increased intensity or time
  - technical difficulty of procedure that is NOT described by a more comprehensive procedure code
  - severity of the patient’s condition
  - increased physical and mental effort required

Assigned to procedures with a 0, 10, 42, or 90 day global period
Do NOT append to E/M service codes

Compliance Rule for Modifier 22

- Applicable when the complications cannot be identified by a separate procedure code
- The procedure took 50% longer to perform and documentation identifies why in good detail.
- The procedure was unusual, requiring 25% more work than usual and the documentation details why.
- The procedure had unusual circumstances or complications, which caused significantly more time, effort, intensity, etc., to perform.

(A well-documented reasonable explanation)

If preparing for certification testing, review the CPT guidelines.

If in a practice, review payer policies to come up with an all-encompassing compliance rule for the use of modifier 22.

Make compliance rules easily accessible to providers and coding staff.
**Modifier 24 Unrelated E/M During P/Op**

**Noridian**

Unrelated Evaluation and Management (E/M) service by the same provider or QHP during a postoperative period.

Use to indicate that an EM or eye Exam, which occurs within a global period of a minor/major surgery (performed by the same MD/QHP) is UNRELATED to the surgery. ONLY applicable to EM service codes.

Documentation should clearly support an unrelated service. A diagnosis code (ICD-10-CM) that differs from that of the surgery is sufficient to explain the modifier and documentation wouldn't need to be submitted.

**Modifier 24 Unrelated E/M During P/Op**

**Novitas**

Same – Same and...

- Explains it can be used starting the day after the procedure
- Documentation indicates the E/M service was “exclusively” for the unrelated diagnosis
- The provider is managing
  - Immunosuppressant therapy during the p/op period of a transplant
  - Chemotherapy during the p/op period of a procedure
- E/M service is for unrelated critical care by same MD/QHP
- SAME DIAGNOSIS but different anatomical site.

**Do NOT Use:**
Surgical complications or infection (incidental)
Removal of sutures or staples (incidental)
Surgeon admits patient to SNF for condition related to surgery
Other surgical procedures performed same day
E/M service is after postoperative period
E/M service is done the same day as the surgery
Modifier 24 Unrelated E/M During P/Op

United Healthcare Community

The physician or other QHP may need to indicate that an E/M service was performed during the 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.

Compliance Rule for Modifier 24

- Check global periods to verify the E/M service took place within a global period of another procedure performed by the same MD/QHP.
- The note must clearly indicate that the E/M service was UNRELATED to the surgical procedure for which the patient has an applicable global period.
- Okay if the MD/QHP managing chemotherapy or immunosuppressant therapy related to the surgical procedure performed.
- Different diagnosis than the surgical diagnosis unless it is for a different anatomical site.

If preparing for certification testing, review the CPT guidelines.

If in a practice, review payer policies to come up with an all-encompassing compliance rule for the use of modifier 24.

Make compliance rules easily accessible to providers and coding staff.
Modifier 24 Unrelated E/M During P/Op

EXAMPLE:
Patient is seen for a lesion removal, with a 10-day global period. Four days later, the patient presents with an upper respiratory infection (URI).

Apply the modifier to the EM service with the URI diagnosis code linked to it.

Modifier 25 Significant/Separately Identifiable E/M

Noridian

A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported

• Beyond the usual pre- or post-operative care associated with the procedure
• Diagnosis (ICD-10-CM) code may be different or the same as the surgery diagnosis
• MUST document history, exam, and MDM (HEM) to qualify
• Don’t have to append -25 to NEW Patient E/M codes (92002, 92004, 99201-99205, 99321-99323, 99341-99345). Automatically excluded from global package
  • Ex: New patient E/M to check for neurologic issues and to repair scalp wound due to head injury (99204, 12032 with no modifier) (12032 has a 10-day global)
• Do Not append if billed with a procedure/service with NO global period
• E/M service reveals patient with myalgia. Provider decides to perform trigger point injections to relieve pain during that same encounter. (99213, 20552) (20552 does not have a global period)
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**Modifier 25 Significant/Separately Identifiable E/M**

**Novitas**

**SAME – SAME**

Novitas defines “SAME PHYSICIAN” as physicians in the same group practice who are of the same specialty.

The E/M service required was above and beyond the usual pre- and post-operative care associated with the procedure or service performed.

Only append when the procedure performed actually has a global period listed.

**Inappropriate Use**

- Used by a MD/QHP other than the one who performed surgery
- Nothing more than the usual pre and post service work was documented
- NEVER with 99211
Modifier 25  Significant/Separately Identifiable E/M

Independence Blue Cross (and Anthem for now)

As of August 1, 2017 IBX slashed payment of the E/M service billed with modifier 25 by 50% billed with a minor procedure.

Anthem BC has stated that as of January 1, 2018 it will do the same.

Providers who perform an E/M and try to schedule the patient to return for a minor procedure to avoid the 50% cut will be found in breach of their contract.

Even in situations where the minor procedure requires less work than the E/M service itself, the E/M will only be paid at 50%.

Expect more payers to get in line with this policy.

Compliance Rule for Modifier 25

• Check payer contracts for policy updates or changes.
• Unless individual payer policy states otherwise, the following qualify:
  • New patient visit when the E/M service results in a decision to perform a minor (10 day global) surgical procedure.
  • Different diagnosis than the E/M service.
  • Procedure and E/M service have the same diagnosis but the procedure was NOT scheduled or anticipated.
  • Exacerbation of a condition which after an E/M service is determined to require a procedure.
  • A new condition.

If preparing for certification testing, review the CPT guidelines.

If in a practice, review payer policies to come up with an all-encompassing compliance rule for the use of modifier 25.

Make compliance rules easily accessible to providers and coding staff.
**Modifier 25  Significant/Separately Identifiable E/M**

**Would You Append Modifier 25?**

1. The provider reported 99214-25 and a minor procedure code. Review of the medical record revealed a chief complaint and HPI followed by the Details of the Procedure.

2. Patient is referred to an orthopedic surgeon as a new patient with water on the knee from a traumatic dislocation injury during a basketball game. The provider performs an E/M service and decides to aspirate the fluid from the knee (arthrocentesis with 0 global days).

3. The patient is scheduled for the third in a series of four hyaluronan injections into the bilateral knees. At his visit he tells the provider he isn’t seeing much improvement and wonders if he should continue with the injections. The provider performs an evaluation and examination and recommends the patient continue through the scheduled injections and performs them for that encounter as planned.

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**Modifier 59  Distinct Procedural Service**

**National Correct Coding Initiative (NCCI)**

- Medicare identifies code pairs & bundles them.
- A two-columned table identifies code pairs that are bundled into each other.
- When a Column 1 code is billed with a Column 2 code, the Column 2 code will be denied.
- Column 2 codes with a status indicator of 1 (superscript) are eligible for modifier 59, if the circumstances are appropriate.
- Modifier 59 overrides the NCCI edit and makes the Column 2 code eligible for payment as well as the Column 1 code.

**NCCI Indicators**

- 0 – Modifier will NOT override the edit
- 1 – Modifier can override the edit

**Documentation MUST support the modifier because by using it the provider is claiming they should be paid more than what is customary.**

**Online resources**

NCCI edits can be located on the Medicare website or online coding software like FindACode, 3M, and others.
Modifier 59  Distinct Procedural Service

Noridian

Modifier 59 identifies procedures/services that are not normally reported together, but are appropriate under the circumstances.

Represent –
- Session or patient encounter
- Procedure or Surgery
- Site or Organ System
- Separate incision or excision
- Separate lesion or injury

Correct Use:
- Procedures performed in different encounters on the same day
- Two timed services provided during the same encounter but done sequentially
- Diagnostic procedure preceding a therapeutic procedure when the diagnostic procedure is the basis for performing the therapeutic procedure.
- Diagnostic procedure subsequent to a completed therapeutic procedure, when it is not a common, expected, or necessary follow-up to the therapeutic procedure.

Incorrect Use:
- Never appended to E/M
- Using it just to bypass NCCI edits
- If another modifier is more appropriate
- Should not be used in place of other modifiers (RT, LT, 50, etc.)

Novitas

SAME – SAME

Additionally
- Report the X [ESPU] Modifiers if possible.
- Verify whether HCPCS National Code modifiers are more appropriate for reporting multiple procedures to various fingers (FA, F1-F9), toes (TA, T1-T9), and eyelids (E1-E4).
- Separate lesion, injury, site, organ system, procedure, surgery, or session.

Inappropriate Use
- Never append to an E/M service
- Documentation MUST support the separate and distinct status
- Not used to indicate multiple administration of injections of the same drug
- Don’t waste your time if the NCCI modifier indicator is “0”
Modifier 59  Distinct Procedural Service

Medicare released new X {ESPU} modifiers to replace modifier 59.

- **XE** – Separate **Encounter**: Distinct service because it occurred during a separate encounter. Should only be used to describe separate encounters on the same date of service.
- **XS** – Separate **Structure**: Distinct because it was performed on a separate organ/structure
- **XP** – Separate **Practitioner**: Distinct because it was performed by a different practitioner
- **XU** – Unusual Non-Overlapping Service: Distinct because it does not overlap usual components of the main service.

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Blue Cross Blue Shield of Tennessee

*Consistent with the initiatives of the Office of Inspector General (OIG) the state they have the right to evaluate, audit, and/or recoup any and all payments resulting from erroneous reporting of modifier 59.*

**Guidelines**

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

- Combination of procedure codes represent procedures that wouldn’t be performed at the same time (procedure on the head and feet)
- Different session or patient encounter documented in medical record
- Surgical procedures performed are not through the same incisional site (doesn’t matter if instrumentation changes, only if incision or presentation is the same).
- Surgical knee procedures involving multiple compartments of the same knee
- Another modifiers is not more appropriate
Compliance
Rule for Modifier 59

• Ensure easy access to NCCI edit tables
• Only append modifier 59 when there is an NCCI edit
• Never append it to an E/M service
• Understand and train providers on Medicare X {EPSU} modifiers so documentation can properly support their use.
• Identify procedures performed regularly that fall within the decision making for modifier 59.

If preparing for certification testing, review the CPT guidelines.

If in a practice, review payer policies to come up with an all-encompassing compliance rule for the use of modifier 59.

Make compliance rules easily accessible to providers and coding staff.

Contact Information

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