Understanding Modifiers and Avoiding Pitfalls

ASCRS-ASOA Symposium & Congress Practice Management Program
San Diego, California
April 17-21, 2015

Presented by: Patricia J. Kennedy, COMT, CPC, COE

Financial Interest

I acknowledge a financial interest in the subject matter of this presentation.

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 professional to effectively respond to payment policy requirements established by other entities.”

-Source: 2015 CPT

Modifiers

- Modifiers are:
  - Integral part of billing process
  - Permit services to be paid that would otherwise be denied
- Modifiers are needed to:
  - Ensure proper payment
  - Prevent excessive denials and lost revenue
  - Identify special circumstances
  - Permit payment in global fee period

Modifiers

- Incorrect or missing modifiers are the most common reasons claims are denied
- Modifiers may also trigger an audit
- Modifiers can change from year-to-year
  - Resources should be current
- Modifiers alert 3rd party payers that special circumstance warrants payment
Modifiers Needing Attention

**Modifier -24**
- Appended to the exam that:
  - Occurs during the post-op period
  - Is provided by surgeon or member of the surgeon's group practice
  - Is unrelated to the surgery
- Example:
  - Complaint of foreign body sensation in fellow eye following cataract surgery

**Modifier -24**
- Glaucoma exam following cataract surgery
- BDR visit following ptosis repair
  - Do not use modifier -24 on office visits for:
    - Complications of surgery
    - Post-op follow-up visits
    - Second eye surgery exam if visit addresses first eye
  - Frequent target for audit

**Modifier -25**
- Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service
  - "Same physician" includes all physicians within a group practice

**Modifier -25**
- Same day minor procedures and exams
  - Universally bundled
    - Office Visit Typically Denied
  - Modifier -25 Appended to Office Visit
    - Both Services Likely Paid
      - Would payment withstand post-payment review?
    - Does it meet the requirements of Modifier -25?
  - Frequent target for audit

**Modifier -25**
- “It may be necessary to indicate that on the 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 other service provided or associated with the procedure that was performed.”
  - Source: CPT Coding Manual
**Modifier -25**

- This modifier is not used to report an E/M service that resulted in a decision to perform surgery
  - See Modifier -57
    - Modifier -57 applies to major surgery not minor surgeries or procedures

- Does NOT apply to new patients for Medicare
  - Doesn’t hinder processing if applied
  - RAs don’t always know this rule
  - May be required by commercial carriers
- New patient is defined as any patient who has not been seen by a physician of same specialty in the practice in the previous 3 years

**Modifier -57**

- Initial evaluation to determine need for major surgery
  - 90 day global fee period
- Surgery occurs within 24 hours of exam
  - Not to be used for re-examination of patient after surgical decision has been made

**Modifier -58**

- Staged or related procedure by same physician during post-op period
  - Planned or anticipated before original procedure
  - More extensive than original procedure
  - Added therapy following a surgical procedure
  - Does not apply to multiple retinal laser procedures
- Global Fee Period restarts
- Does not apply if planning a “return to the OR”
- Only appended to surgery codes

**Modifier -73**

- Used to document that surgery performed in ASC was terminated before the administration of anesthesia (block, local, general, or topical)
  - Payment will be at 50% of allowable
    - Elective cancellation of a service prior to administration of anesthesia and/or surgical preparation of the patient should not be reported

**Modifier -74**

- Used to identify a procedure performed in an ASC that was terminated after the administration of anesthesia (block, local, general, or topical), or after the procedure was started
  - Full payment will be made
    - Elective cancellation of a service prior to administration of anesthesia and/or surgical preparation of the patient should not be reported
### Modifier -78
- Unplanned return to operating room during the post-operative period
  - Intrinsically related to original surgery
- Operating room defined by Medicare as:
  - Hospital OR
  - Ambulatory surgery center OR, or
  - Designated procedure room/OR in physician’s office

### Modifier -78
- Reimbursement is 80%
  - Equates to the surgical portion of global fee
- Global fee period does NOT restart
  - Original post-op period is followed
- Only appended to surgery codes
- Not to be used for repeat procedures

### Modifier -79
- Indicates unrelated service or procedure during global fee period
  - Different condition
  - Fellow eye
- New post-operative period begins with the unrelated procedure
  - If minor procedure, the original post-operative period may still apply

### Multi-Applicable Modifiers

### Modifier -50
- Bilateral service in the same session
  - Per Medicare, surgical procedures must now be billed with the -50 modifier
  - Indicate "1" unit
  - Double charge
  - Payment is 150% of Medicare’s allowable
    - Example: 15823-50 BULB – 1st eye 100%, 2nd eye 50%
  - Use varies by 3rd party payer
    - May still require -RT and -LT modifiers

### Modifier -RT and -LT
- Indicates laterality of service
  - Unilateral service
    - Do not append to services defined as “unilateral or bilateral”
      - Example: 92133, 92134, 92083
    - Do append to diagnostic tests defined as unilateral (per eye) services
      - Example: 92225, 92235
    - Report on two line items
      - Anatomical modifiers are always appended as LAST modifier
### Modifier -51

- Multiple services in the same session
  - Highest paying procedure is reported first
    - Append modifier -51 to 2nd, 3rd, 4th procedure, etc.
      - Reduces subsequent procedures by 50%
    - Medicare no longer requires modifier -51
      - Technical component of 2nd, and subsequent tests performed on same day reduced by 20%
      - Medicare may automatically append -51 for reduction
    - Does not apply to add-on codes

### Modifier -52

- Service or procedure is partially reduced or eliminated
  - Physician may feel procedure did not require full reimbursement
  - When billing Medicare, should append -52 modifier to bilateral diagnostic tests when only one eye tested
    - Does not apply to tests described as “unilateral or bilateral”
    - Do not reduce charge

### Other Modifiers

#### Modifiers -TC and -26

- Diagnostic tests
  - Technical component (-TC modifier)
    - The process of performing the test
      - Subject to 20% reduction on 2nd, 3rd, etc. tests
  - Professional component (-26 modifier)
    - The physician’s interpretation and report of the test results
  - Not applicable to physician services
    - For example: gonioscopy, extended ophthalmoscopy

### Modifier -53

- Discontinued procedure by physician
  - Surgery terminated prior to completion
    - Procedure has to have been started by the surgeon (surgical opening made)
  - May need to fax copy of operative report when electronic claim filed
  - Don’t reduce charge - Medicare will determine payment

### Modifier -54

- Indicates surgical care only
  - Lets Medicare know the patient will be co-managed
  - Major surgery - 20% reduction
  - Requires transfer of care agreement in patient chart
**Modifier -55**

- Post-operative management only
  - If surgeon provides initial post-op care, must append modifier -55 to portion of post-op care provided
  - Must indicate when care relinquished
  - Co-manager then bills for portion of post-operative care he/she provides using -55 modifier as well
  - Must indicate date care assumed and relinquished in Item 19 of CMS-1500 (or EMC equivalent)

**Modifier -59**

- Distinct Procedural Service
  - Procedures/services not normally reported together
    - NCCI lists the two services as bundled or mutually exclusive
  - Documentation must support a different:
    - Session or patient encounter
    - Procedure or surgery
      - Must be different anatomical site or organ system, or

**“X” Modifiers**

- Instead of modifier -59 where applicable
  - XE – Separate Encounter
  - XS – Separate Structure
    - Separate organ/structure
  - XP – Separate Practitioner
  - XU – Unusual Non-Overlapping Service
    - Does not overlap usual components of main service
  - Found in back of CPT coding manual

**Modifiers -76 and -77**

- Repeat procedure or service performed subsequent to the original procedure
  - Modifier -76
    - Procedure or service repeated by same physician
  - Modifier -77
    - Procedure repeated by another surgeon
  - Surgical modifiers only
    - Do not append to tests or exams

**Modifiers E1 – E4**

- Procedures performed on specific eyelid
  - E1 – Upper left, eyelid
  - E2 – Lower left, eyelid
  - E3 – Upper right, eyelid
  - E4 – Lower right, eyelid
  - Do not use if the service is paid per eye
Modifier -GA

- Advance Beneficiary Notice of Non-Coverage (ABN) complete and on file
  - Item or service is expected to be denied as not reasonable and necessary
  - Applies to items or services that are sometimes paid by Medicare
  - Modifiers -GA and -GY should not be appended to the same item or service

Modifier -GY

- Item or service statutorily excluded
  - Applies to items or services that are never covered by Medicare
  - ABN includes non-covered items or services excluded from Medicare coverage
  - The patient has the option of having claim submitted to Medicare
  - Unnecessary to append to refractions

Avoiding Scrutiny

- Medicare considers all doctors in a group practice to be considered the “same” doctor with regard to providing post-operative care
  - Patient develops edema following cataract surgery and sent to retina doctor to treat
    - Office visit not billable
    - Treatment billable if it requires a “return to OR” (-78 modifier)

Avoiding Scrutiny

- Modifiers are located in the back of the CPT coding manual
  - Conduct internal audits to make sure requirements are being met
  - Hold in-services as needed if requirements are not met
    - Include billers and coders as well as technicians and nurses
      - Remember, just because Medicare paid it doesn’t mean it was paid appropriately
**In Summary**

- Correct use of modifiers can improve reimbursement when medical records are documented properly
  - Without supporting documentation, claim could be denied in post-payment audit
- Overuse or incorrect modifiers could subject practice to:
  - Overpayment and refund requests
  - Penalties for fraudulent billing
  - Possible prepayment scrutiny

**Questions**

Rose & Associates
1-800-720-9667
results@roseandassociates.com
www.roseandassociates.com