



Integrated Revenue Integrity

Modifier Madness

Let's get this right!

Julie Hall, COC
Principal

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Why are Modifiers Needed?

- Modifiers provide additional information in relation to how the procedure was performed, where the procedure was performed and why the procedure was performed.
- CMS implemented National Correct Coding Initiative (NCCI) Edits in 1996 to promote correct coding and to control improper coding of Part B claims.
- Medically Unlikely Edits (MUEs) were created in 2007 to prevent billing incorrect units of service.



Where Do Your Modifiers Come From

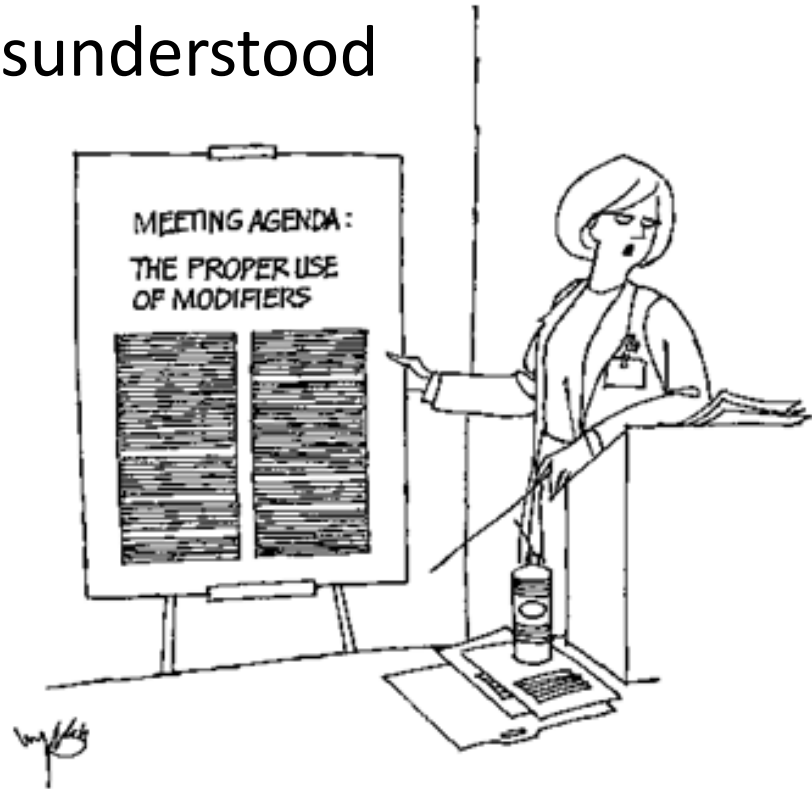
- Hard Coded
- Soft Coded
- HIM
- Clinical Departments
- Patient Accounts



Modifiers Discussed Today

- Modifiers commonly misunderstood

- 59 , XE, XP, XS, XU
- 25
- 33,PT
- 52,53
- 73,74





Modifier 59

The CPT Manual defines modifier 59 as follows:

“Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. **Documentation must support** a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.”



Modifier 59

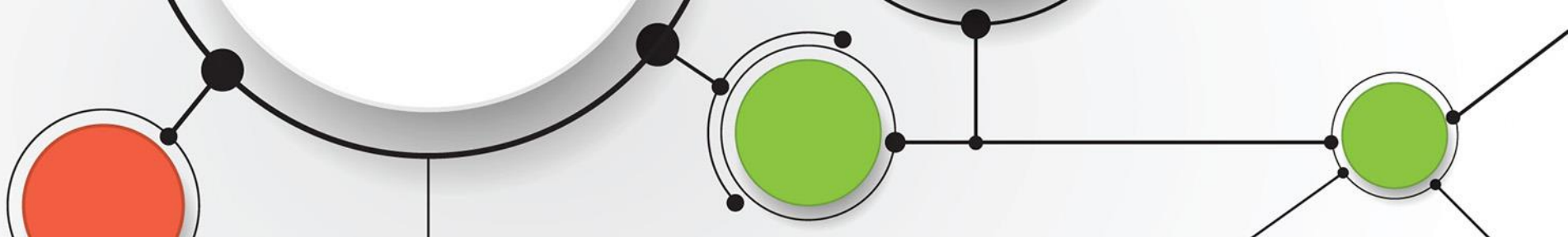
- Modifier 59 allows two separate services or procedures which would usually be prohibited by NCCI edits to reside on the same claim and both be paid.
- This modifier has been used as a “catch-all” modifier, and per CMS, has been consistently used erroneously.
- If there is a more precise modifier that clarifies the billing situation, the other modifier must be used in lieu of modifier 59.

Hospitals need to be careful not to abuse the use of modifier 59



Modifiers XE, XP, XS, XU

- These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.)
- Although NCCI will eventually require use of these modifiers rather than modifier 59 with certain edits, providers may begin using them for claims with dates of service on or after January 1, 2015.



Modifiers XE, XP, XS, XU

XE – “Separate encounter, A service that is distinct because it occurred during a separate encounter”

XP – “Separate Practitioner, A service that is distinct because it was performed by a different practitioner”

XS – “Separate Structure, A service that is distinct because it was performed on a separate organ/structure”

XU – “Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service”



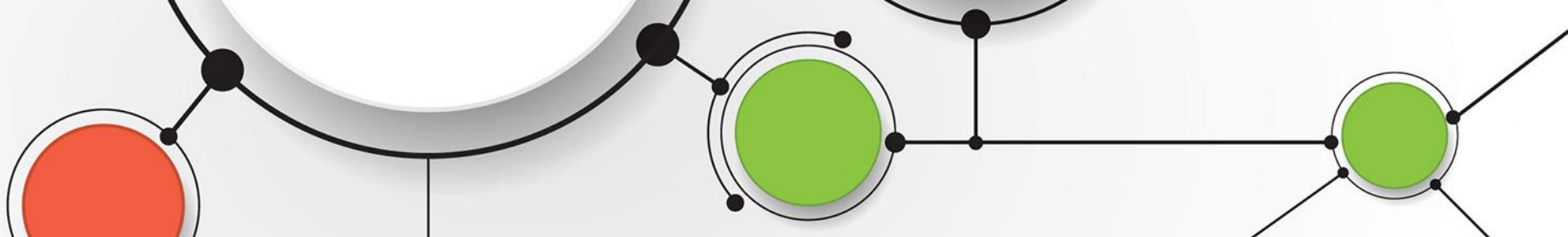
Modifier XE

Example #1:

Patient has a tube thoracostomy (32551) performed at 10:00 am and is discharged home.

Later that day, patient presents to the ED with complaints of chest pain and a two-view x-ray (71046) is performed.

Per NCCI edits, 71046 is a component of 32551.



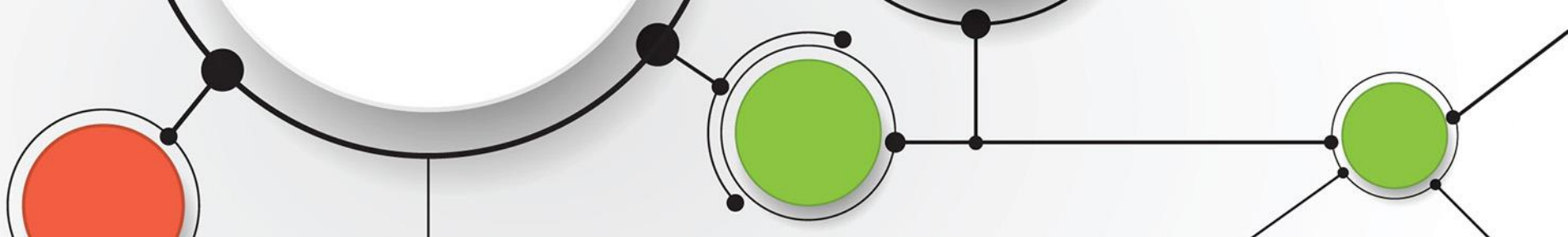
Modifier XE

Example #1 (*continued*) :

How would you report this on your claim?

361 32551
320 71046XE

Why: Because the services were performed during two separate encounters, modifier XE is appropriate.

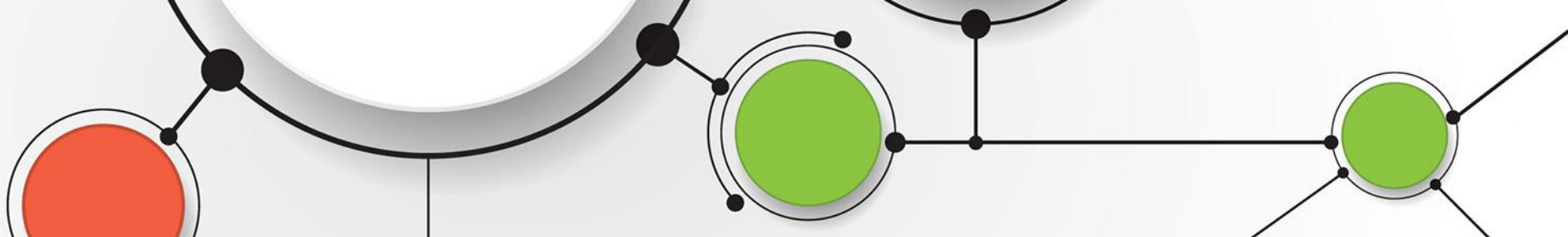


Modifier XS

Example #2:

Patient falls and sustains injuries to palm of hand and knee. Physician performs incision and removal of embedded foreign body in palm (10120) and closes the wound with two sutures. Physician then performs simple laceration repair of a 2.3 cm laceration of the knee (12001).

Per NCCI edits, 12001 is a component of 10120.



Modifier XS

Example #2 (*continued*) :

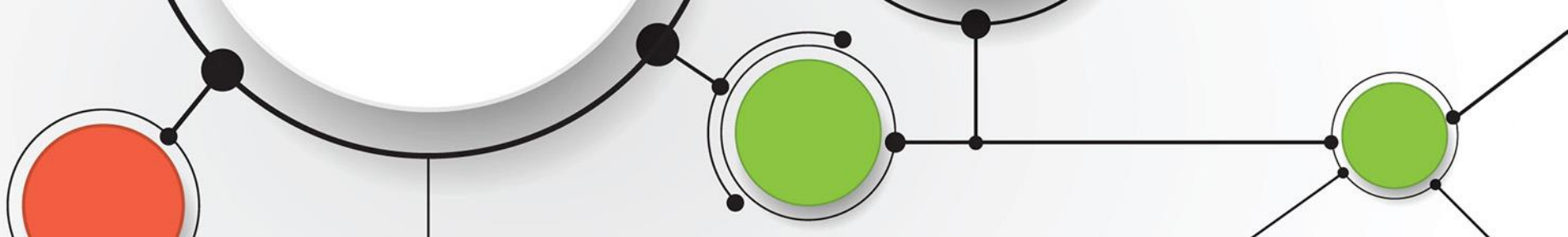
How would you report this on your claim?

361	10120
361	12001XS

Why:

Because the services were performed on two different structures (palm & knee), modifier XS is appropriate.

Providers should evaluate other modifiers such as the RT/LT identifying right and left, FA – F9 to identify fingers, TA-T9 to identify toes and E1-E4 to identify eyelids.

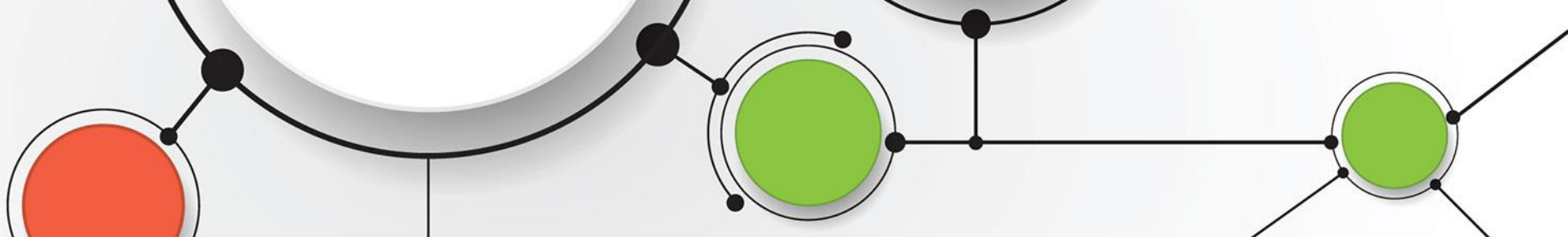


Modifier XU

Example #3:

Two separate lesions are present within the transverse colon (same organ/structure); one is removed by snare (45385), the second is removed with cold biopsy forceps (45380).

Per NCCI edits, 45380 is a component of 45385.



Modifier XU

Example #3 (*continued*) :

How would you report this on your claim?

750 45385

750 45380XU

Why: Because the second service performed was not part of the usual components of the main service, modifier XU is appropriate.

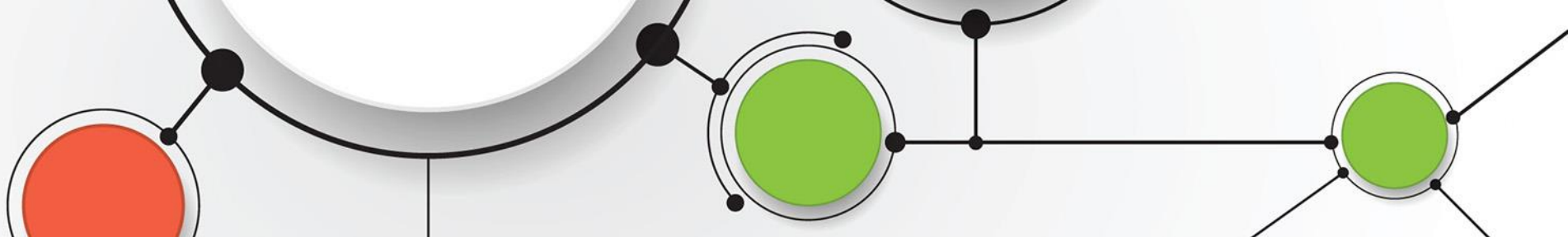


When NOT to Use a Modifier

Example #4:

David arrives at the outpatient surgery center for a shoulder arthroscopy (29806). The nurse starts an IV, documents this and the system charges (96365) because David will be receiving antibiotics per protocol.

Per NCCI edits, 96365 is a component of 29806.



When NOT to Use a Modifier

Example #4 (*continued*):

What will the claim look like?

260 96365

361 29806

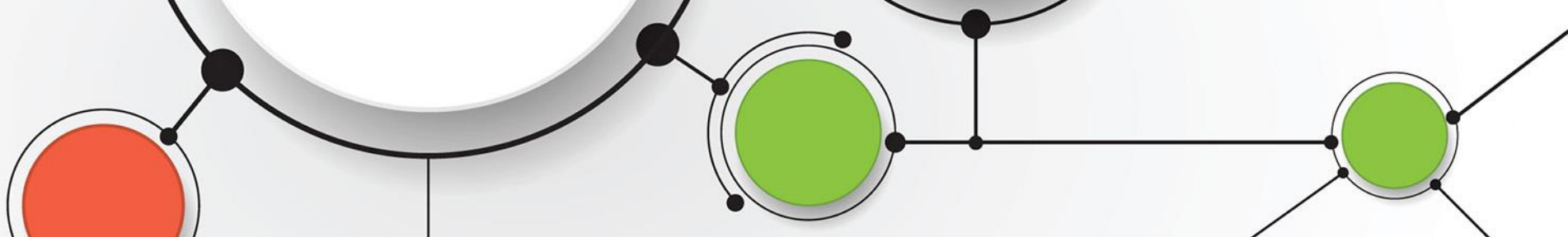
Will this hit an edit on the scrubber?

Yes

Should a modifier be added to 96365?

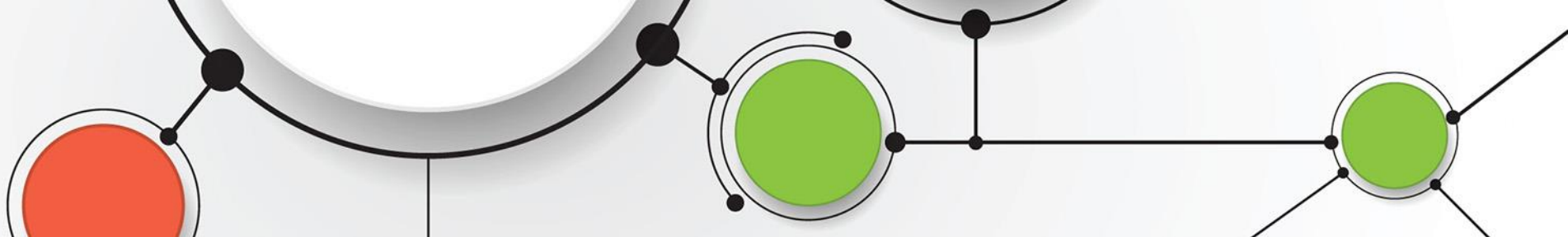
No!

Why: The infusion is considered part of the surgical services being provided; it is ***not*** separate and distinct and therefore adding a modifier would not be appropriate.



Modifier 25

- **Significant, Separately Identifiable E&M by Same Provider on Same Day**
- Documentation in the record must substantiate the E&M service as separate
- Different diagnoses are not required



Modifier 25

Example #5:

Emily is seen by her pediatrician for a cough and low grade fever that has lasted for three days. During the exam, her mother mentions she has a wart on her hand that has not gone away with OTC treatment. The provider decides to freeze the wart today.

- Would modifier 25 be appropriate in this scenario?



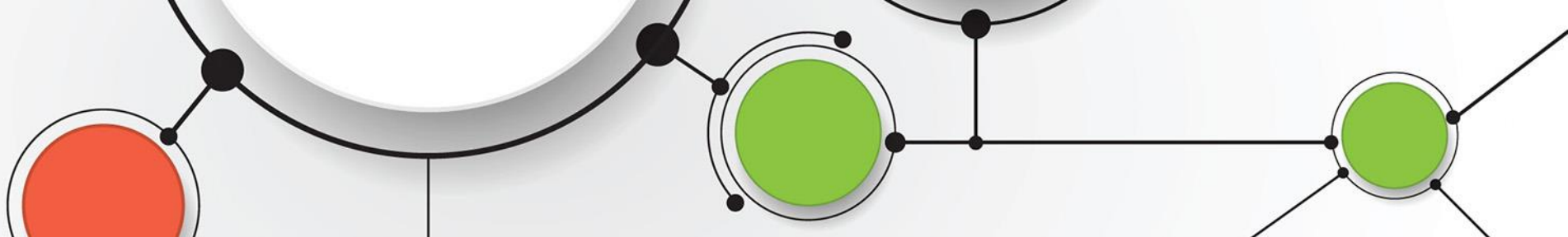
Modifier 25

Example #5 (continued):

Yes, because the wart destruction was separate and distinct from the reason for the E&M modifier 25 would be appropriate.

510 17110

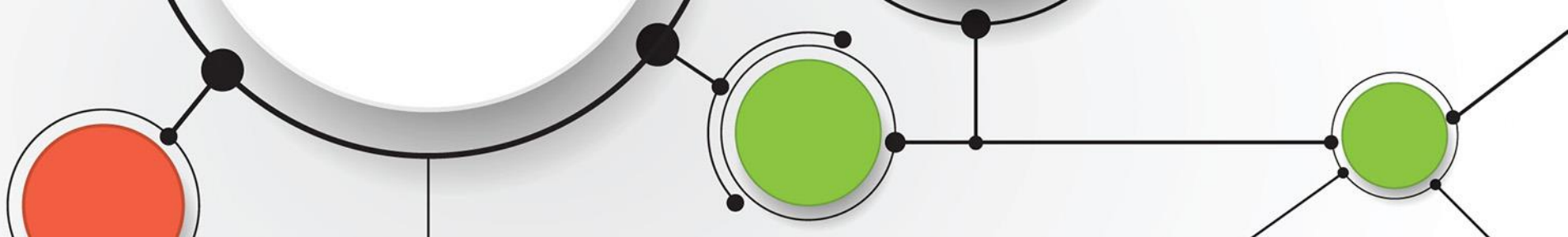
510 9921325



Modifiers 33 and PT

Modifier 33 – Preventive Services: when the primary purpose of the service is the delivery of an evidence based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used

PT- Colorectal cancer screening test; converted to diagnostic test or other procedure



Modifiers 33 and PT

Modifier 33 was created because under the ACA non-grandfathered health plans are prohibited from billing cost sharing on preventative services.

The presence of modifier 33 will waive deductible and co-insurance.

The presence of modifier PT will waive deductible.

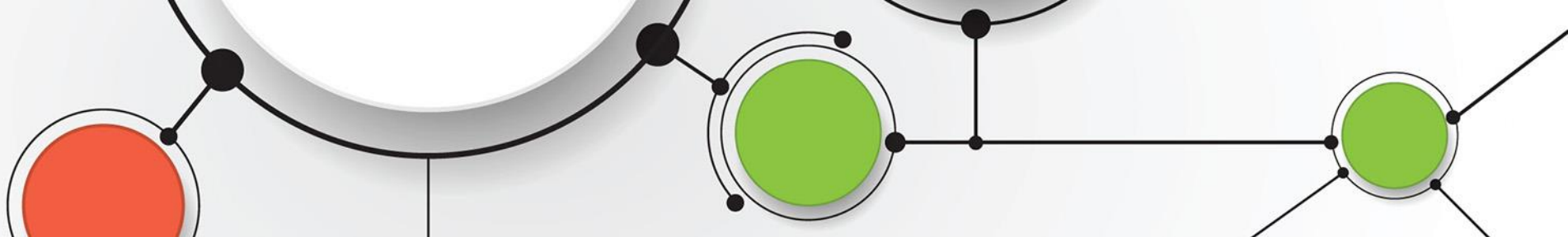


Modifiers 33 and PT

IOM 100-04, Chapter 18 Section 60.1.1

NOTE: *Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 and coinsurance and deductible are waived. When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 and with the PT modifier; only the deductible is waived.*

Coinsurance and deductible are waived for moderate sedation services (reported with G0500 or 99153) when furnished in conjunction with and in support of a screening colonoscopy service and when reported with modifier 33. When a screening colonoscopy becomes a diagnostic colonoscopy, moderate sedation services (G0500 or 99153) are reported with only the PT modifier; only the deductible is waived.



Modifiers 33 and PT

Examples #6 & #7:

Jon, who is considered high risk, is scheduled for a screening colonoscopy with conscious sedation.

750	G0105
370	G050033

Mary is scheduled for a screening flexible sigmoidoscopy and a biopsy was performed on a growth.

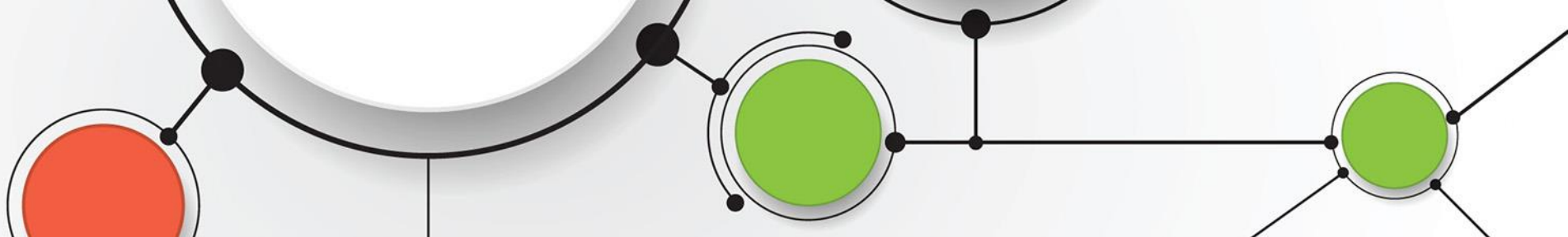
750	45331PT
370	G0500PT



Modifier 52

52 Reduced Services

- Used to identify a service or procedure that was partially reduced or eliminated at physician's discretion.
- Add modifier to intended procedure.
- Use when the full CPT/HCPCS description is not met.
- Usually coded by HIM
- May be in CDMs for "single view" x-rays.



Modifier 52

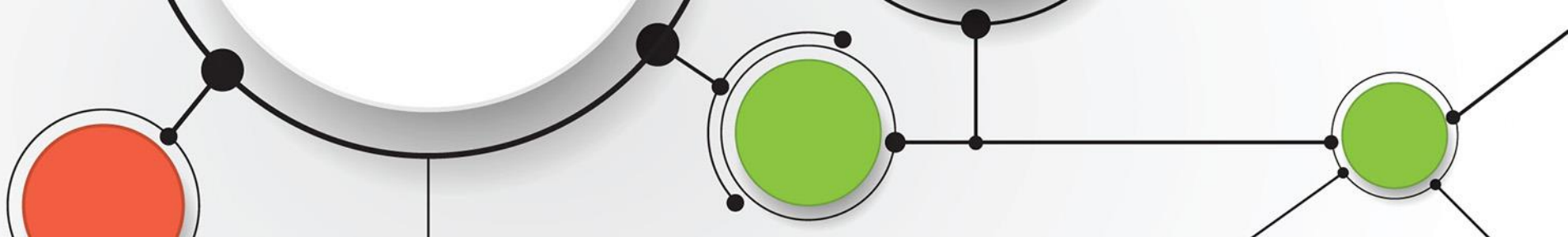
52 Reduced Services

Example #8:

Dr. Smith orders a single view hand x-ray on Diana to check a healing fracture.

CPT 73120 Hand x-ray, two views is the lowest amount of views for a hand x-ray. Report with modifier -52 to indicate reduced services

320 7312052 1 125.00



Modifier 52

52 Reduced Services

Example #9:

Commonly misused for Low Dose CT (LDCT) Scanning

Wrong: 7125052 CT Thorax w/o contrast

Right: G0297 Low dose CT Scan for lung cancer screening

Check your chargemaster!



Modifier 53

53 Discontinued Service

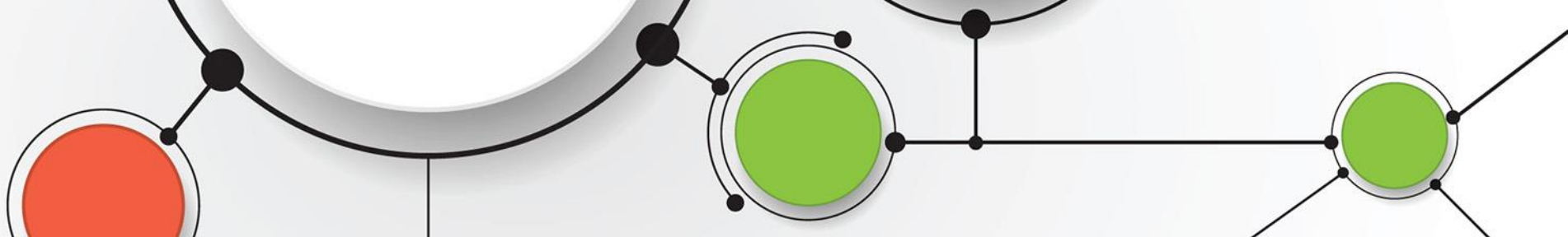
- Used to identify a service or procedure that was discontinued.
- Add modifier to intended procedure.
- Extenuating circumstances, procedure was started
- Usually coded by HIM
- Do not use on hospital claims, professional claim only



Modifier 73

73 Discontinued OP Hospital/ASC Procedure Prior to Administration of Anesthesia

- Used to identify a procedure that was discontinued after surgical prep but before anesthesia
 - Local, regional or general
- Includes sedation given and patient taken to the room where procedure is to be performed
- Add modifier to intended procedure.
- Extenuating circumstances, not elective cancelation
- Usually coded by HIM



Modifier 74

74 Discontinued OP Hospital/ASC Procedure After Administration of Anesthesia

- Used to identify a procedure that was discontinued after anesthesia was given
 - Local, regional or general
- Incision made, intubation started, scope inserted, etc.
- Add modifier to intended procedure.
- Extenuating circumstances, not elective cancelation
- Usually coded by HIM

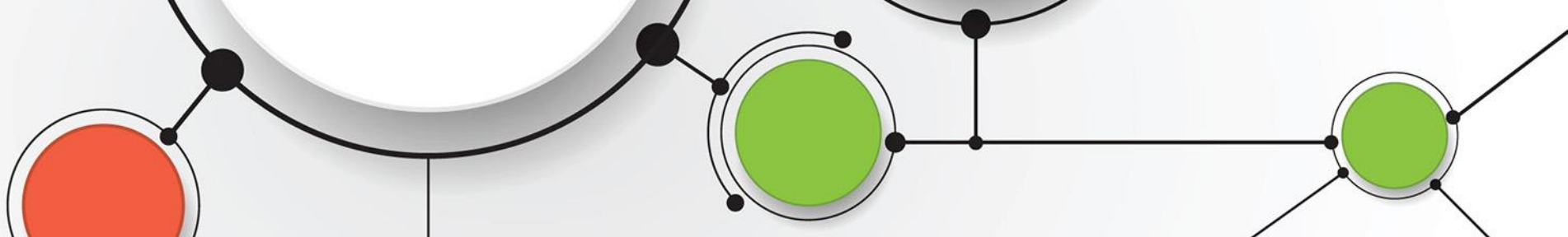


Modifier 73 or 74

Example #10:

Mrs. Jones arrives at the hospital outpatient surgical center for carpal tunnel release. The nurse brings the patient to the pre-op area to begin prep. During the interview Mrs. Jones states she forgot she was not to eat after midnight and had a small breakfast. The nurse informed the surgeon and anesthesiologist and a decision was made to re-schedule the surgery.

Would the hospital bill the intended surgical procedure with a modifier 73 or 74?



Modifier 73 or 74

Example #10 (continued):

It would not be appropriate to bill the surgical procedure with either modifier.

The hospital could bill an E&M facility fee based on their hospital policy to account for the resources used, e.g., registration, nursing, etc.

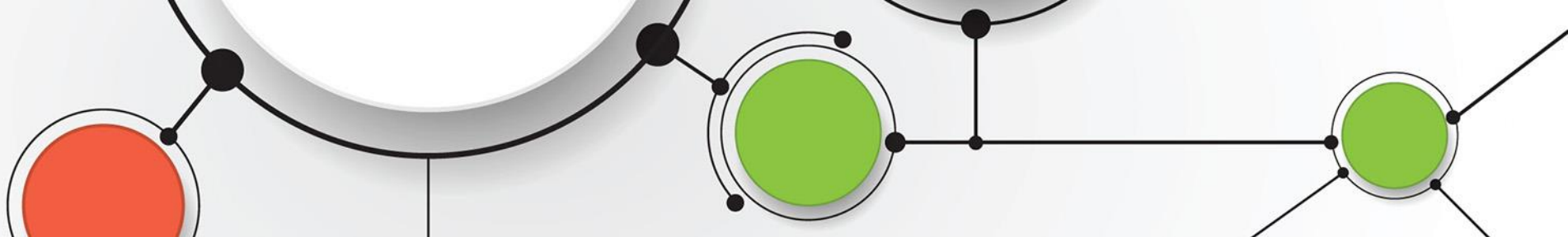


Modifier 73 or 74

Example #11:

Mr. Davis was scheduled to have his knee replaced in the hospital outpatient department. He was fully prepped, sedation was given and he was brought to the operating room. Dr. Arty was ready to initiate anesthesia when Dr. Ortho became ill and decided to postpone the procedure.

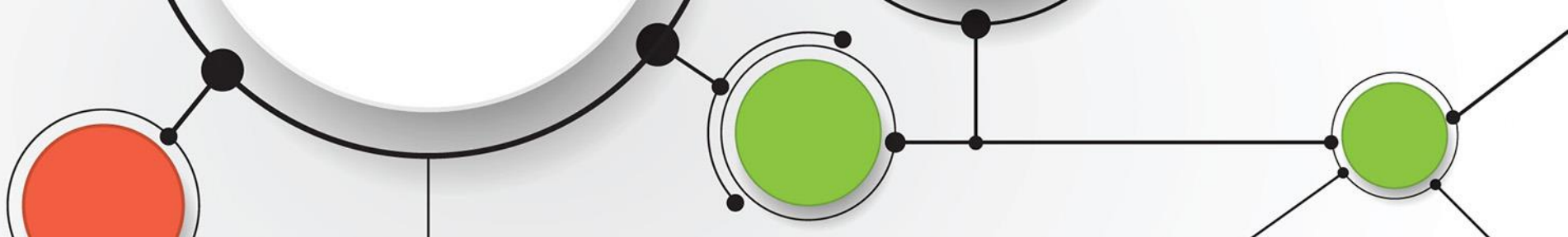
Would it be appropriate for the hospital to append modifier 73 or 74 in this scenario?



Modifier 73 or 74

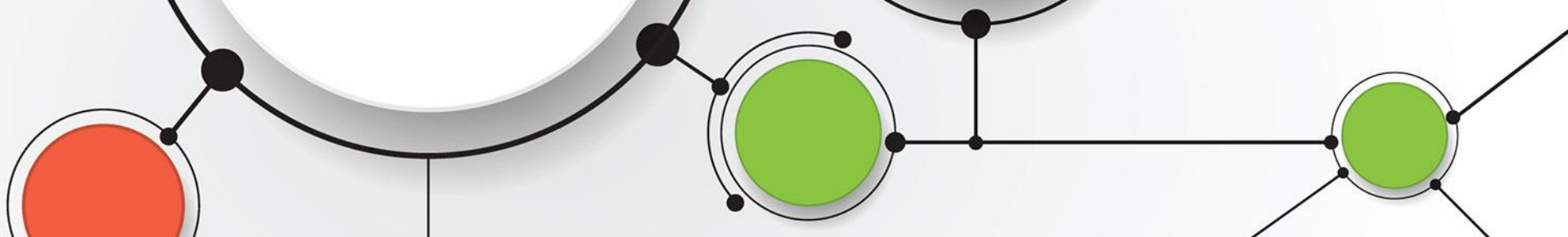
Example #11 (continued):

Yes, the hospital would append modifier 73 to the intended procedure because the patient was prepped, brought to the room and the procedure was canceled prior to anesthesia.



Order of Modifiers

- Correct sequencing of modifiers is very important
- Modifiers that impact payment always go first
 - 25, 50, 52, 59
- Informational modifiers go second
 - LT, RT, 33, PT



Order of Modifiers

Examples: **Right** or **Wrong**

Bilateral 2 view Elbow X-ray

73070LTRT50



Single view right forearm

7309052RT



Suture, separate site, left

12002LT59





Resources

- IOM Manual Chapter 4 Part B Hospital:
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf>
- MM8863 Specific Modifiers for Distinct Procedural Services
- SE1503 Continued Use of Modifier 59 after January 1, 2015
- MM9246 Medicare Coverage of Screening Lung Cancer w/LDCT
- MM9930 January 2017 Update OPPS
- 33/PT: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf>
- MM10417 January 2018 Update OPPS



Questions?

info@integratedri.com