

Reporting Hospital Outpatient Modifiers

Audio Seminar/Webinar

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Practical Tools for Seminar Learning

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Faculty

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***To Modify or Not to Modify . . .
That is the Question***

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Questions



- ◆ What is a modifier?
- ◆ When is a modifier appropriate?
- ◆ Are all modifiers appropriate for all settings?
- ◆ Which modifier is appropriate for a particular situation?
- ◆ What does the OIG say about the use of modifiers?

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Polling Question 1

Who is responsible for assigning modifiers in your facility?

- *1 HIM coding staff
- *2 Patient accounts billing staff
- *3 Clinical coding staff
- *4 Modifiers are automatically applied by the clinical/financial computer system
- *5 All may apply



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What is a Modifier?
Why would you need one?

- ◆ **Two digits attached to CPT codes**
 - Numbers
 - Letters
 - Combination



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What is a Modifier?
Why would you need one?

Adds specificity to the procedure code

- **Provides further information on the service**
 - Defines circumstances and alterations of services
 - Identifies anatomical site
- **May affect reimbursement**

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Circumstances

- ◆ **Let the carrier/fiscal intermediary know that "There's something different about this claim."**
 - **Multiple procedures were performed, multiple sites were involved, or multiple operative episodes occurred on the same day (59)**
 - **The service is a "significant, separately identifiable" service on the same day as the procedure (25)**
 - **The procedure was discontinued or "We performed most but not all of the steps in the procedure." (52, 73, 74)**

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OIG's Opinion Regarding Modifier Usage

- ◆ **Outpatient Department Payments**

"We will review payments to hospital outpatient departments under the prospective payment system to determine the extent to which they were made in accordance with Medicare laws and regulations. We will review the appropriateness of payments made for multiple procedures, repeat procedures, and global surgeries."

(OAS; W-00-06-35193; W-00-06-35065 ;various reviews; expected issued date: FY 2007; work in progress)

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CPT Level I Modifiers

- ♦ -25 Separate significant evaluation and management service
- ♦ -27 Multiple outpatient hospital evaluation and management encounters on the same date
- ♦ -50 Bilateral procedure
- ♦ -52 Reduced service
- ♦ -58 Staged or related procedure or service by the same physician
- ♦ -59 Distinct procedural service

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CPT Level I Modifiers continued

- ♦ -73 Discontinued outpatient procedure prior to anesthesia
- ♦ -74 Discontinued outpatient procedure after anesthesia
- ♦ -76 Repeat procedure by same physician
- ♦ -77 Repeat procedure by another physician
- ♦ -78 Return to the OR for a related procedure
- ♦ -79 Unrelated outpatient procedure or service by the same physician
- ♦ -91 Repeat clinical diagnostic lab test

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Modifier -25

- ◆ **Criteria for use of modifier -25:**
 - **Significant clinical service**
 - **Separately identifiable clinical service**
 - **Performed by the same provider on the same day as a procedure or other service**
 - **Required on status indicator "V" codes**



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Example - Modifier -25

An 82 year old patient is seen in the ED with a superficial 5 cm laceration of the 4th digit of the right hand. The wound is cleaned and sutured. The provider evaluates other contusions and abrasions. Nursing staff provides written material and routine instructions to the patient. Patient is told to return to ED or to family physician in one week for suture removal.

- 99282-25 Low complexity ED visit
- 12002-F8 Simple repair of superficial wound of extremity, 2.6 to 7.5 cm (4th digit right hand)

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Modifier -27

◆ **Multiple outpatient hospital E/M encounters on the same date of service**

Used for hospital outpatient reporting purposes to report utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings/clinics on the same day



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Example - Modifier -27

Patient is seen in the hospital's Family Medicine clinic by Dr. Smith complaining of arm pain. Treated with muscle relaxant and sent home. Later that same day, the patient is seen in the ENT clinic for a follow-up appointment with Dr. Thompson for his chronic hearing loss.

99211-27 Low level clinic visit (Dr. Smith)

99212-27 Low level clinic visit (Dr. Thompson)

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Modifier -50



♦ **Bilateral Procedures**

- **Only reported when:**
 - A procedure is performed on both sides of a paired organ (extremities, eyes, breasts, ears, etc.)
- **and**
- The CPT surgical code description does not indicate "bilateral" or "unilateral or bilateral"
- **Billed on one line**
- **Modifiers "LT" and "RT" should not be used when modifier -50 applies**

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Example - Modifier -50

Patient presented with a very strong family history of early-onset of breast CA and mammogram indicating extensive fibrocystic disease and a few scattered microcalcifications. She is admitted for bilateral prophylactic simple mastectomies.

**19303-50 Mastectomy, simple, complete
(billed w/ 1 unit)**

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Polling Question 2

Which of the following modifiers is not used to indicate a discontinued radiology procedure?

- *1 52
- *2 73
- *3 74
- *4 Both 73 and 74



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Modifier -52

♦ Reduced Services

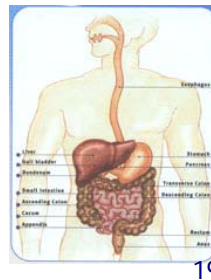
- Reported when a service is partially reduced or eliminated at the physician's discretion.
 - Modifier -52 is primarily used for discontinued imaging procedures, bilateral services or other services for which anesthesia is not required
 - Elective cancellation of the procedure is not reported
 - The procedure which is reduced does not require anesthesia
 - If anesthesia is planned or administered, do not use modifier -52. Use modifier -73 or -74

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Example - Modifier -52

**Patient presented for capsule endoscopy of the GI tract.
The ileum was not visualized.**

91110-52 GI tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum



Modifier -58

- ◆ **Staged procedure or service by the same physician on the same day of the initial procedure or service.**
 - Use this modifier to indicate that the procedure or service was:
 - **Planned prospectively at the time of the original procedure or staged**
 - **More extensive than the original procedure**
 - **For definitive treatment following a diagnostic surgical procedure**

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Example - Modifier -58

Patient has abnormal uterine bleeding. She is admitted for diagnostic D&C with possible TVH depending on results of pathology.

58120 D&C, diagnostic

58260-58 TVH/BSO for uterine cancer

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Modifier -58



PLEASE NOTE:

- **A new postoperative period begins THE NEXT CALENDAR DAY**
- **Modifier -58 is not used when treatment is for complication of original surgery**

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Modifier -59

- ♦ **Distinct procedure or service**
 - **Separate body site**
 - **Separate incision**
 - **Separate operative episode**



Modifier -59 is used to identify services that are not normally reported together but are appropriate under the circumstances

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Example - Modifier -59

Colonoscopy performed for rectal bleeding. Findings on endoscopy revealed a suspicious tumor at the rectosigmoid junction which was removed by snare and additional sites of suspicious tissues in the ascending colon. These sites were biopsied.

45385 Colonoscopy w/tumor removal
 45380-59 Colonoscopy w/biopsies

Only appropriate if performed on separate lesions

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Modifier -73

- ◆ Discontinued OP Hospital/ASC procedure prior to administration of anesthesia



- After patient is prepped (including pre-procedure meds if required)
and
- After patient is taken to procedure room
and
- Before administration of anesthesia

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Polling Question 3

CMS defines anesthesia as:

- *1 Local, regional blocks
- *2 Moderate sedation/analgesia (“conscious sedation”)
- *3 Deep sedation/analgesia
- *4 General anesthesia
- *5 All the above



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Example - Modifier -73

47 year old male brought to the endoscopy suite for diagnostic EGD. Patient prepped. After moving the patient to the procedure room, and prior to initiation of sedation, he develops significant hypotension and the physician cancels the procedure.

43235-73 Diagnostic EGD

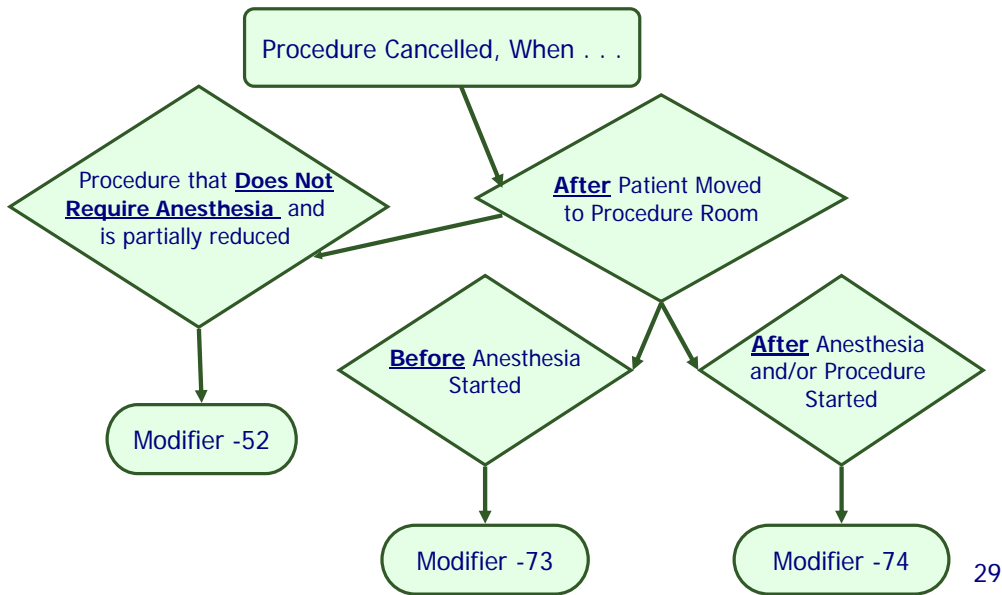
27

Modifier -74

- ◆ **Discontinued OP Hospital/ASC procedure after administration of anesthesia OR after the the procedure was started**
 - **Scope inserted, intubation started, incision made**
 - **Discontinued due to well being of patient**
 - **In order to use modifiers 73 and 74 the patient has to be taken to the room where the procedure is to be performed**

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Decision Tree – Modifier Use When Procedure/Surgery is Cancelled



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Modifier -78



- ◆ **Return to the OR for related procedure during the postoperative period (same day)**

This modifier indicates that complications arose to necessitate a return trip to the Operating Room. The term “operating room” includes a cardiac catheterization suite, a laser suite or an endoscopy suite

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Example - Modifier -78

45 year old male admitted for T&A. Three hours after leaving the surgery center, the patient presents to the clinic with a 1-hour history of bleeding "from the back of my throat". The bleeding site was located, however, it was in a location that could not be treated outside the OR. The patient was taken back to the OR for control of postop bleeding.

42821	Tonsillectomy and adenoidectomy, age 12 or older
42962-78	Control oropharyngeal hemorrhage with secondary surgical intervention

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Modifier -79

- ◆ **Unrelated procedure or service by the same physician during the postoperative period**

This modifier indicates that there was a procedure performed during the (same day) postoperative period which was not related to any post-operative complication (Not to be used with a staged procedure)

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Example - Modifier -79

58 year old female with carpal tunnel symptoms who presented today for surgery. Carpal tunnel release was performed on her right wrist. On the way home from surgery, the patient is involved in a car accident and requires further surgery. Luckily her orthopaedic surgeon was available to perform an open reduction of her left fibula shaft fracture.

64721-RT Carpal tunnel release

27784-79-LT Open treatment of fibular fracture

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Modifier -91

- ◆ **Repeat clinical diagnostic laboratory test**
 - Same test
 - Same day
 - Subsequent (multiple) test results
- ◆ **NOT if test is rerun**
 - To confirm initial results
 - Due to problems with specimen or equipment



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Example - Modifier -91

72 year old male admitted via the ED in acute respiratory failure. Patient was intubated and placed on mechanical ventilation. ABGs obtained in the ED immediately prior to intubation, followed by 2 additional sets of ABGs on the same day, one at 2 hrs post-intubation and one at 4 hrs post-intubation.

- 82803 ABGs, any combination of pH, PCO2, PO2, CO2, HCO3 (including calculated O2 saturation)
- 82803-91 As above
- 82803-91 As above

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HCPSCS Anatomical Modifiers

LT- Left side	E1- Upper left, eyelid
RT- Right side	E2- Lower left, eyelid
LC- Left circumflex coronary artery	E3- Upper right, eyelid
RC- Right circumflex coronary artery	E4- Lower right, eyelid
LD- Left anterior descending coronary artery	
FA- Left hand, thumb	F5- Right hand, thumb
F1- Left hand, second digit	F6- Right hand, second digit
F2- Left hand, third digit	F7- Right hand, third digit
F3- Left hand, fourth digit	F8- Right hand, fourth digit
F4- Left hand, fifth digit	F9- Right hand, fifth digit
TA- Left foot, great toe	T5- Right foot, great toe
T1- Left foot, second toe	T6- Right foot, second toe
T2- Left foot, third toe	T7- Right foot, third toe
T3- Left foot, fourth toe	T8- Right foot, fourth toe
T4- Left foot, fifth toe	T9- Right foot, fifth toe

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Example - Anatomical Modifiers

Patient with bunion on left foot, great toe, and second and third toes. Physician performs a McBride bunionectomy of the great toe, and osteotomy with lengthening on the second and third toes.

- 28292-TA Correction, hallux valgus (bunion), with or w/o sesamoidectomy, simple exostectomy
- 28308-T1 Osteotomy, other than first metatarsal, each
- 28308-T2 Osteotomy, other than first metatarsal, each



Additional Info: Status Indicators

♦ **Status Indicators**

Significant procedure, not discounted when multiple

- T- Significant procedure, multiple reductions apply
- V- Clinic or emergency department visit

Example:

Status Code

- V 99213-25 Clinic visit service
- T 11603 Removal of skin lesion (chest)
- T 11603-59 Removal of skin lesion (back)

Status Indicators *continued*

♦ **Another example of Status Indicators**

Example:

Status Code

- | | | |
|---|-------|--|
| T | 50021 | Drainage of perirenal or renal abscess, percutaneous |
| S | 75989 | Radiological guidance for percutaneous drainage |

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National Correct Coding Initiative (CCI)

- ♦ **The outpatient PPS brought CCI edits to hospital outpatient claims**
- ♦ **As of April 1, 2007, there are 288,473 active edit pairs**
- ♦ **The purpose of CCI edits is to identify instances where**
 - **“Component” service code(s) are billed during the same encounter as associated “comprehensive” service code(s)**
 - **Two procedures considered to be “mutually exclusive” are performed/billed during the same encounter**

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References

- ♦ **AHA Coding Clinic for HCPCS, Volume 5, 4th Quarter 2005, pages 14 and 16**
- ♦ **CMS direction to assign modifier 25 in the ED**
<http://oig.hhs.gov/hospitaloutpatientpps/downloads/a0040.pdf>
<http://oig.hhs.gov/hospitaloutpatientpps/downloads/a0180.pdf>
- ♦ **Hospital Outpatient Prospective Payment System (OPPS): Use of Modifiers-52, -73, -74 for Reduced or Discontinued Service**
<http://www.cms.hhs.gov/transmittals/downloads/R442CP.pdf>
- ♦ **OIG Fiscal Year 2007 Work Plan**
<http://oig.hhs.gov/publications/docs/workplan/2007/Work%20Plan%202007.pdf>

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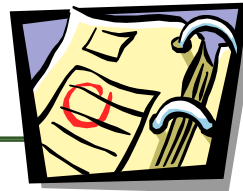
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