Reporting Hospital Outpatient Modifiers

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The faculty has reported no vested interests or disclosures regarding this presentation.
Faculty

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Objectives

- Review current AMA coding guidelines for modifier assignment

- Update coders' knowledge of current regulatory guidelines when assigning CPT modifiers

Objectives

- Review how to choose between similar modifiers and apply applicable modifiers using case scenarios

- Review the reimbursement impact of modifiers under OPPS
What Are Modifiers?

- A two-digit code
- Placed after the CPT/HCPCS procedure code
- Provides information about the procedure
- May affect reimbursement

Modifier Usage Guidelines

- Not all procedure codes require modifiers
- Use of modifiers eliminates appearance of unbundling and duplicate billing
- Not appropriate if narrative description of procedure applies to different body parts or indicates multiple occurrences
Modifier Usage Guidelines

- Modifiers apply to services performed on the same calendar day
- Most specific modifier should be used first
  - Ex - FA, F9 are used before LT, RT or 50
- Hyphen should not be entered with modifier (-50 vs. 50)

Medicare Claims Processing Manual, chapter 4, sections 20.6-20.6.9

Polling Question #1

At your facility, who is responsible for hospital outpatient modifier assignment?

*1 HIM
*2 Patient Financial Services
*3 Clinical Department(s)
*4 Chargemaster (hard-coded)
*5 Depends on modifier, department, and circumstance
CPT Level I Hospital Modifiers

- Indicate special circumstances
  - Multiple procedures performed
  - Separately identifiable service performed
  - Procedure was discontinued

- If more than one Level I modifier applies, both can be reported together with the CPT/HCPCS

Examples:

<table>
<thead>
<tr>
<th>25</th>
<th>27</th>
<th>50</th>
<th>52</th>
</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>59</td>
<td>73</td>
<td>74</td>
</tr>
<tr>
<td>76</td>
<td>77</td>
<td>78</td>
<td>79</td>
</tr>
</tbody>
</table>
HCPCS Level II Modifiers

- Add specificity to the reporting of procedures
- If more than one Level II modifier applies, the CPT/HCPCS is repeated with the additional modifier

Examples:

<table>
<thead>
<tr>
<th>CA</th>
<th>E1 - E4</th>
<th>FA - F9</th>
<th>GA</th>
</tr>
</thead>
<tbody>
<tr>
<td>GG</td>
<td>GH</td>
<td>GN</td>
<td>GO</td>
</tr>
<tr>
<td>GP</td>
<td>LC</td>
<td>Q0 - Q1</td>
<td>RC</td>
</tr>
</tbody>
</table>
E/M Modifiers - Modifier 25

- Significant, separately identifiable E/M service
  - OPPS status indicator “V” (clinic or emergency department visit)
- Only reportable with E/M service when the same physician on the same day performed a diagnostic medical or surgical and/or therapeutic medical or surgical procedure is performed

E/M Modifiers - Modifier 25

- Modifier is appended to E/M code
- OIG November 2005 report and CMS contractor awareness
E/M Modifiers - Modifier 25

Patient is brought to the hospital emergency department for a possible right ankle fracture. The provider evaluates the patient through the use of plain film x-rays. Ultimately it is found that the patient has a bimalleolar ankle fracture. The provider treats the fracture (closed without manipulation) and a short leg walking cast is applied.

- 99283-25  Moderate complexity ED visit
- 27808-RT  Closed treatment of fracture
- 29425-RT  Cast application
**E/M Modifiers - Modifier 27**

- Multiple E/M encounters on same calendar day
  - OPPS status indicator “V” (clinic or emergency department visit)
- Modifier is appended to second or subsequent E/M
- Condition code is required if E/M is in same revenue center on same day
- Regulatory scrutiny

An established patient is seen in the Wound Care Clinic in the morning for evaluation of a new wound. She is evaluated; no treatment is performed. She is given a prescription. She fills the prescription and within hours has an allergic reaction. She is taken to the ED (same outpatient center) that evening. She is evaluated, treated, and discharged. No surgical interventions, radiological exams, or laboratory tests were performed.
E/M Modifiers - Modifier 27

- 99213 Established patient, moderate clinic visit
- 99283-27 Moderate complexity ED visit

E/M Modifiers - Modifier 25/27

In the previous scenario, the patient receives a partial thickness debridement of her wound in the Wound Care Clinic.
E/M Modifiers - Modifier 25/27

- **99213-25** Established patient, moderate clinic visit
- **11040** Debridement of skin, partial thickness
- **99283-27** Moderate complexity ED visit

Modifier 52

- Partially reduced or discontinued services
- Not for elective cancellation
- Services that do not require anesthesia (see 73 - 74)
**Modifier 52**

- Usually identify interrupted or reduced radiology exams or other diagnostic services
  - Code to the extent of the procedure performed
  - If no code exists, report the intended code
- Cannot be submitted with E/M services

Patient is scheduled for a GI series (CPT 74240). The examination could not be completed. The patient could not tolerate the barium.
Modifier 52

- **74240-52** Upper GI series, without KUB

Patient is scheduled for a CT scan of the lumbar spine (CPT 72133) with and without contrast. The patient ended up only having a CT scan of the lumbar spine without contrast.
Modifier 52

- 72131 CT of lumbar spine, without contrast

Polling Question #2

Patient presents for a diagnostic colonoscopy. The procedure cannot be completed due to poor preparation. Would it be appropriate to report the procedure as 45378-52?

*1 Yes

*2 No


**Modifier 73**

- Procedure is discontinued or cancelled after patient has been prepared for surgery and/or prior to the induction of anesthesia
- Apply to procedures requiring anesthesia
- Apply when the well-being of the patient is threatened
- Procedure must be discontinued in the room where the procedure was to be performed in order to assign modifier

**Modifier 74**

- Procedure is discontinued or cancelled after administration of anesthesia or after the procedure has begun
- Apply when the well-being of the patient is threatened
- Procedure must be discontinued in the room where the procedure was to be performed in order to assign modifier
Modifier 73/74

- When one or more of the planned procedures is completed, report the completed procedure without Modifier 73/74.
- When none of the procedures that were planned were completed, report the first procedure with Modifier 73/74.

Discontinued Svs Decision Tree
Polling Question #3

Patient is scheduled for a diagnostic EGD. As the patient begins preparation, he develops significant hypotension. The physician cancels the procedure. Anesthesia has not been administered. The patient has not been moved into the procedure room. How should this procedure be reported?

*1 43235-73
*2 43235-52
*3 43235
*4 None of the above

Modifier 59

- Identifies procedures not normally reported together, but are done so under certain circumstances
- Append modifier to the procedure considered distinct, independent or lesser service
- Cannot be appended to an E/M service
**Modifier 59**

- Use only when another modifier is not more descriptive
- OIG and CMS contractor scrutiny

**Modifier 59 and NCCI Edits**

- The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported
- The NCCI contains two tables of edits
Modifier 59 and NCCI Edits

- The Column One/ Column Two Correct Coding Edits table and the Mutually Exclusive Edits table include code pairs that should not be reported together.
- NCCI edits are published by CMS and can be found online [http://www.cms.hhs.gov/NationalCorrectCodInitEd/](http://www.cms.hhs.gov/NationalCorrectCodInitEd/)

The NCCI Edit Table

- Column 1/ Column 2 Correct Coding Edits apply to code combinations where one of the codes is a component of a more comprehensive code.
- The edit allows payment for the comprehensive code only.
Polling Question #4

Patient has an ECG (CPT 93005) completed in morning at the Cardiology Clinic. The results are abnormal and the physician orders a stress echocardiogram (CPT 93350 and 93015) to be completed in the afternoon.

Audience Poll #4

In reviewing the NCCI table Column 2 edits, would it be appropriate to report Modifier 59 for this combination?

*1 Yes
*2 No

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Effective Date</th>
<th>Deletion Date</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>93015</td>
<td>93005</td>
<td>19960101</td>
<td>^</td>
<td>1</td>
</tr>
<tr>
<td>93016</td>
<td>93005</td>
<td>19960101</td>
<td>^</td>
<td>1</td>
</tr>
<tr>
<td>93017</td>
<td>93005</td>
<td>19960101</td>
<td>^</td>
<td>1</td>
</tr>
<tr>
<td>93018</td>
<td>93005</td>
<td>19960101</td>
<td>^</td>
<td>1</td>
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<tr>
<td>93025</td>
<td>93005</td>
<td>20021001</td>
<td>^</td>
<td>1</td>
</tr>
<tr>
<td>93278</td>
<td>93005</td>
<td>19960101</td>
<td>^</td>
<td>1</td>
</tr>
</tbody>
</table>
**Modifier 59 and Infusion Services**

Report Modifier 59 when

- An infusion that occurs at a second distinct encounter
- The second of two concurrent infusions with two access sites are used and two different drugs are administered
- Modifier 59 should not be appended to infusion or injection codes to allow hydration to be billed primarily

**Modifier 59 and Radiation Oncology**

- *Delivery* 77401 - 77416 or 77418 can be reported with Modifier 59 on the same day as treatment planning and delivery when performed at separate sessions
- *Devices* 77332 - 77334 can be reported with Modifier 59 on the same day as treatment planning
**Modifier 59**

Antibodies for hepatitis C, total and IgM are determined. There is a total of three tests with three results.

86803 x 1  Hepatitis C antibody
86803-59 x 1  Hepatitis C antibody

**Modifier 91**

- Repeat/identical clinical diagnostic laboratory test performed on same day to obtain subsequent test values
- Separate specimens taken during separate encounters
- Tests paid under the clinical diagnostic fee schedule
**Modifier 91...may NOT be used**

- Rerun of tests to confirm results, a problem exists with the specimen or equipment, or any other reason when only a one-time result is required
- Other codes describe a series of test results (e.g., glucose tolerance tests)

**Modifier 91 versus 59 (Labs)**

- Modifier 91 should be used in most cases, however Modifier 59 is a better choice in some situations
- If the same test is performed at the same time with more than one method/specimen, the 2nd, etc. tests are shown with Modifier 59
Polling Question #5

Patient has three separate wound cultures (CPT 87070) initiated on the same day. Each culture is from three different anatomical sites. How would the three cultures be reported?

* 1  87070 x 3
* 2  87070 x 1, 87070-59 x 2
* 3  87070 x 1, 87070-91 x 2
* 4  87070-59 x 1, 87070-91 x 2

Modifiers 76 and 77

• Procedure or service repeated in a separate session on the same day by
  • same physician       (Modifier 76)
  • another physician    (Modifier 77)

• May be reported for services ordered by a physician but performed by a technician
Modifers 76 and 77

- The same procedure must be done in a separate session on the same day
- The procedures are reported on two lines, the second with Modifier 76 or 77

Modifiers LT and RT

- Identify procedures, which can be performed on paired organs
- Used when a procedure is performed on only one side
Modifier 50

- Bilateral procedures performed at the same operative session
- Only for paired organs and body parts
- Do not use with procedures when the narrative description indicates “unilateral or bilateral”, “bilateral”, or multiple occurrences

Modifier 50

- Do not use LT and RT, when 50 applies
- Units of service when modifier is appended remains as 1
**Modifier 50**

Patient presents to the radiology suite for a series of radiological exams. The patient was in an MVA and did not receive immediate treatment. He is complaining of pain in his knees and ankles, bilaterally. The physician has ordered standing bilateral knee films, and bilateral ankle views - two views.

**Modifier 50**

- 73565 Bilateral knees standing
- 73600-50 Ankle two views, done bilaterally
Modifiers - Anatomical Sites

- Add specificity to the procedures
- Modifiers for fingers and toes override Modifier 50
  - Eyelids E1-E4
  - Fingers F1-F9
  - Toes TA-T9
  - Arteries LC, LD, RC

Modifiers - Anatomical Sites

- Do not use LT/RT if a more specific modifier is available
- Applied to surgical codes and other diagnostic services (90281-99569)
- Artery modifiers are required by CMS for coronary stent placement
  - 92980-92982, 92995, 92996
**Modifier GG**

- Performance of a screening mammogram and diagnostic mammogram on the same patient on the same day, separate encounters
- Report both CPT codes for the screening and diagnostic mammogram
- Append Modifier GG to the diagnostic mammogram

**Modifier GG**

Patient comes in for her annual screening bilateral mammogram. After the images are taken she leaves the facility. The radiologist reviews the films and orders additional digital views. The patient is able to return to the facility the same day.
**Modifier GG**

- **76091** Bilateral mammography
- **G0204-GG** Diagnostic mammography producing direct digital image, bilateral, all views

**Modifier GH**

- Diagnostic mammogram converted from screening mammogram on same day, same encounter
- The screening mammogram is used as a diagnostic exam based on findings, additional views are not needed
**Modifier GH**

- Report the diagnostic mammogram CPT only
- Append Modifier GH to the diagnostic mammogram CPT

**Modifier GH**

- Patient comes in for a bilateral screening mammogram. Later, it is determined that this exam should be considered diagnostic.
- 76091-GH  Bilateral mammography
Modifier TS

• Follow-up service for diabetes screening where the beneficiary meets the definition of pre-diabetes
• The modifier indicates the patient’s eligibility for diabetes screening services

Modifier TS

• Append modifier to glucose screening tests (82947, 82950, 82951)
• Coverage and diagnosis coding requirements also apply
**Modifier CA**

- Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies prior to admission
- Applied to any service that is designated with a status indicator “C” indicating that it is an inpatient only service

**Modifier CA ... must be...**

- the patient is outpatient;
- the patient has an emergent, life-threatening condition;
- a procedure on the inpatient-only list is performed on an emergency basis (either ER or OR) to resuscitate or stabilize the patient; **AND**
- the patient dies without being admitted as an inpatient
**Modifier GA**

- Waiver of liability on file
  - Bill services as covered
  - Patient financially liable

**Modifier GY**

- Item or service statutorily excluded or does not meet the definition of any Medicare benefit
  - Bill services as non-covered
  - ABN is not required
  - Patient financially liable
**Modifier GZ**

- Item or service expected to be denied as not reasonable and necessary (No signed ABN)
  - Bill services as non-covered
  - Facility is financially responsible

**Modifier GN**

- Services delivered under an outpatient speech-language pathology plan of care
  - CPT/HCPCS codes billed under revenue code 44X
**Modifier GO**

- Services delivered under an outpatient occupational therapy plan of care
  - CPT/HCPCS codes billed under revenue code 43X

**Modifier GP**

- Services delivered under an outpatient physical therapy plan of care
  - CPT/HCPCS codes billed under revenue code 42X
**Modifiers GN, GO, GP**

- Commonly hard-coded in the facility Chargemaster
- Required for services provided to Medicare beneficiaries

**Modifier Q0**

- Investigational clinical service provided in a clinical research study that is in an approved clinical research study
  - Items and services that are being investigated as an objective within the study
  - Replaces QA and QR
**Modifiers**

**Modifier Q1**

- Routine clinical service provided in a clinical research study that is in an approved clinical research study
  - Items and services that are covered for Medicare beneficiaries outside of the clinical research study
  - Replaces QV

**Modifier 58**

- Staged or related procedure or service by the same physician during postoperative period
- Not used to indicate treatment of a problem requiring return to operating room
**Modifier 58**

- Indicates the procedure was
  - Planned at time of original procedure
  - More extensive than original procedure
  - For therapy following a diagnostic surgical procedure

**Modifier 78**

- Return to the operating room for a related procedure during the postoperative period of initial procedure
- Subsequent procedure is related to initial procedure
**Modifier 78**

- Subsequent procedure requires use of operating room
- Used when complications arise, not a staged procedure
- Assign Modifier 78 to the subsequent procedure

**Modifier 79**

- Unrelated procedure or service by the same physician during the postoperative period
- Assign Modifier 79 to the subsequent procedure
Modifier Coverage and Reimbursement

- The modifiers below will alter payment for the individual CPT/HCPCS procedure code under OPPS

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Short Modifier Description</th>
<th>OPPS Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>Bilateral Procedure</td>
<td>150% of allowed amount</td>
</tr>
<tr>
<td>52</td>
<td>Reduced Service</td>
<td>50% of allowed amount</td>
</tr>
<tr>
<td>73</td>
<td>Discontinued outpatient procedure prior to anesthesia</td>
<td>50% of allowed amount</td>
</tr>
<tr>
<td>CA</td>
<td>Inpatient only procedure performed on outpatient who dies before admission</td>
<td>Allows for payment under APC 977</td>
</tr>
</tbody>
</table>

- Others do not impact payment, other than allowing payment due to the inclusion of the modifier that otherwise would not be allowed or to direct financial liability to the patient or accept as a facility

- Detailed reimbursement impact is provided in the Appendix
Resource/Reference List

• Useful Web Sites:
  • www.cms.hhs.gov CMS
  • www.cdc.gov/nchs ICD-9-CM addeda and guidelines
  • www.ama-assn.org CPT information
  • www.cms.hhs.gov/medicare/hcpcs.default.asp HCPCS level II coding
  • www.oig.hhs.gov OIG
• AHIMA’s Coding Assessment and Training Solutions® Modifier Use in Hospitals http://campus.ahima.org/campus/course_info/CATS/CATS_info.html

Audience Questions
Audio Seminar Discussion

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• Network with other AHIMA members
• Enhance your learning experience

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**Wound Care Coding**  
*Faculty:* Gloryanne Bryant, RHIA, RHIT, CCS and Ella James, MS, RHIT, CPHQ  
*April 24, 2008*

**Understanding and Using ICD-10-CM**  
*Faculty:* Nelly Leon-Chisen, RHIA, and Sue Bowman, RHIA, CCS  
*May 1, 2008*

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Certificates will be awarded for AHIMA Continuing Education Credit
Appendix

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## REVENUE IMPACT TABLE

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Short Modifier Description</th>
<th>OPPS Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>Significant, separately identifiable E/M service</td>
<td>No Impact</td>
</tr>
<tr>
<td>27</td>
<td>Multiple E/M same day</td>
<td>No Impact</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral Procedure</td>
<td>150% of allowed amount</td>
</tr>
<tr>
<td>52</td>
<td>Reduced Service</td>
<td>50% of allowed amount</td>
</tr>
<tr>
<td>58</td>
<td>Staged or Related Procedure</td>
<td>No Impact</td>
</tr>
<tr>
<td>59</td>
<td>Distinct Procedural Service</td>
<td>No Impact</td>
</tr>
<tr>
<td>73</td>
<td>Discontinued outpatient procedure prior to anesthesia</td>
<td>50% of allowed amount</td>
</tr>
<tr>
<td>74</td>
<td>Discontinued outpatient procedure after anesthesia</td>
<td>No Impact</td>
</tr>
<tr>
<td>76</td>
<td>Repeat procedure by same physician</td>
<td>No Impact</td>
</tr>
<tr>
<td>77</td>
<td>Repeat procedure by another physician</td>
<td>No Impact</td>
</tr>
<tr>
<td>78</td>
<td>Return to OR for related procedure</td>
<td>No Impact</td>
</tr>
<tr>
<td>79</td>
<td>Unrelated procedure or service by same physician in post op period</td>
<td>No Impact</td>
</tr>
<tr>
<td>91</td>
<td>Repeat clinical diagnostic lab test</td>
<td>No Impact</td>
</tr>
<tr>
<td>CA</td>
<td>Inpatient only procedure performed on outpatient who dies before admission</td>
<td>Allows for payment under APC 977</td>
</tr>
<tr>
<td>E1-E4</td>
<td>Eyelids</td>
<td>No Impact</td>
</tr>
<tr>
<td>FA-F9</td>
<td>Fingers</td>
<td>No Impact</td>
</tr>
<tr>
<td>GA</td>
<td>Liability waiver on file</td>
<td>Potential patient financial liability</td>
</tr>
<tr>
<td>GG</td>
<td>Screening and diagnostic mammogram on same day, separate encounters</td>
<td>Both mammograms will be paid at 100%</td>
</tr>
<tr>
<td>GH</td>
<td>Screening mammogram converted to diagnostic on same day</td>
<td>No Impact</td>
</tr>
<tr>
<td>GN</td>
<td>Speech Language Pathologist</td>
<td>No Impact</td>
</tr>
<tr>
<td>GO</td>
<td>Occupational Therapist</td>
<td>No Impact</td>
</tr>
<tr>
<td>GP</td>
<td>Physical Therapist</td>
<td>No Impact</td>
</tr>
<tr>
<td>GY</td>
<td>Item or service is statutorily excluded</td>
<td>Potential patient financial liability</td>
</tr>
<tr>
<td>GZ</td>
<td>Item or service is expected to be denied</td>
<td>Potential facility financial liability</td>
</tr>
<tr>
<td>LC</td>
<td>Left circumflex coronary artery</td>
<td>No Impact</td>
</tr>
<tr>
<td>LD</td>
<td>Left anterior descending coronary artery</td>
<td>No Impact</td>
</tr>
<tr>
<td>LT</td>
<td>Left side</td>
<td>No Impact</td>
</tr>
<tr>
<td>Q0</td>
<td>Investigational service as part of approved study</td>
<td>No Impact</td>
</tr>
<tr>
<td>Q1</td>
<td>Routine service provided as part of approved study</td>
<td>No Impact</td>
</tr>
<tr>
<td>RC</td>
<td>Right coronary artery</td>
<td>No Impact</td>
</tr>
<tr>
<td>RT</td>
<td>Right side</td>
<td>No Impact</td>
</tr>
<tr>
<td>TA-T9</td>
<td>Toes</td>
<td>No Impact</td>
</tr>
<tr>
<td>TS</td>
<td>Diabetes screening for pre-diabetes</td>
<td>No Impact</td>
</tr>
</tbody>
</table>
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http://campus.ahima.org/audio/2008seminars.html

click on

“Complete Online Evaluation”

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