AHIMA
Distance Education

Reporting Hospital Outpatient Modifiers

Audio Seminar/Webinar

April 17, 2008

Disclaimer

The American Health Information Management Association makes no representation or guarantee with respect to the contents herein and specifically disclaims any implied guarantee of suitability for any specific purpose. AHIMA has no liability or responsibility to any person or entity with respect to any loss or damage caused by the use of this audio seminar, including but not limited to any loss of revenue, interruption of service, loss of business, or indirect damages resulting from the use of this program. AHIMA makes no guarantee that the use of this program will prevent differences of opinion or disputes with Medicare or other third party payers as to the amount that will be paid to providers of service.

CPT$^®$ five digit codes, nomenclature, and other data are copyright 2007 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein.

As a provider of continuing education, the American Health Information Management Association (AHIMA) must assure balance, independence, objectivity and scientific rigor in all of its endeavors. AHIMA is solely responsible for control of program objectives and content and the selection of presenters. All speakers and planning committee members are expected to disclose to the audience: (1) any significant financial interest or other relationships with the manufacturer(s) or provider(s) of any commercial product(s) or services(s) discussed in an educational presentation; (2) any significant financial interest or other relationship with any companies providing commercial support for the activity; and (3) if the presentation will include discussion of investigational or unlabeled uses of a product. The intent of this requirement is not to prevent a speaker with commercial affiliations from presenting, but rather to provide the participants with information from which they may make their own judgments.

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

Faculty

Caroline Rader, MBA, MSHCA, CHC, is an associate director with Navigant Consulting, Inc.'s Revenue Cycle practice in Baltimore, MD. Ms. Rader provides consulting services to nationally recognized hospital systems, specifically related to outpatient billing compliance and charge capture processes. She has been an author and speaker for the Health Care Compliance Association and for the Maryland Chapter of AHIMA.

Shelley C. Safian, MAOM/HSM, CCS-P, CPC-H, CHA, is chair of the allied health department of Herzing College in Winter Park, FL. Ms. Safian has had four books on coding published, with a fifth book on health information management compliance in the works. She has been a member of AHIMA for many years, and sits on the Clinical Terminology and Classification Practice Council. Ms. Safian is presently working on her PhD in Health Services Administration.
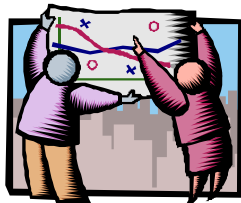
Table of Contents

Objectives

- **Review current AMA coding guidelines for modifier assignment**

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

1

Objectives

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

- **Review the reimbursement impact of modifiers under OPPS**

2

What Are Modifiers?
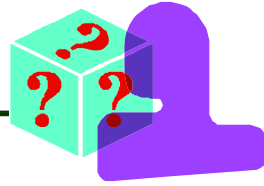
- **A two-digit code**
- **Placed after the CPT/HCPCS procedure code**
- **Provides information about the procedure**
- **May affect reimbursement**

3

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**

4

Modifier Usage Guidelines

- **Modifiers apply to services performed on the same calendar day**
- **Most specific modifier should be used first**
    - **<u>Ex</u> – 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   5

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**

6

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**

7

CPT Level I Hospital Modifiers

Examples:

25	27	50	52
58	59	73	74
76	77	78	79

8

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**

9

HCPCS Level II Modifiers

Examples:

CA	E1 - E4	FA - F9	GA
GG	GH	GN	GO
GP	LC	Q0 - Q1	RC

10

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**

11

E/M Modifiers - Modifier 25

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

12

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.

13

E/M Modifiers - Modifier 25

- **99283-25   Moderate complexity ED visit**
- **27808-RT   Closed treatment of fracture**
- **29425-RT   Cast application**
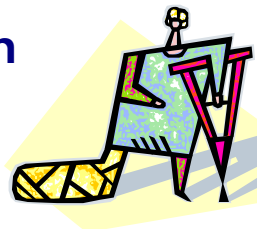
14

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**

15

E/M Modifiers - Modifier 27

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.

16

E/M Modifiers - Modifier 27

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

17

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.

18

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**

19

Modifier 52

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

20

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**

21

Modifier 52

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

22

Modifier 52

- **74240-52   Upper GI series, without KUB**
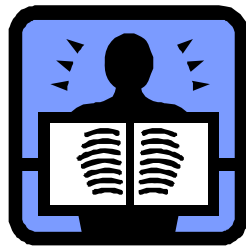
23

Modifier 52

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.

24

Modifier 52

- **72131   CT of lumbar spine,
  without contrast**

25

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

26

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**

27

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**
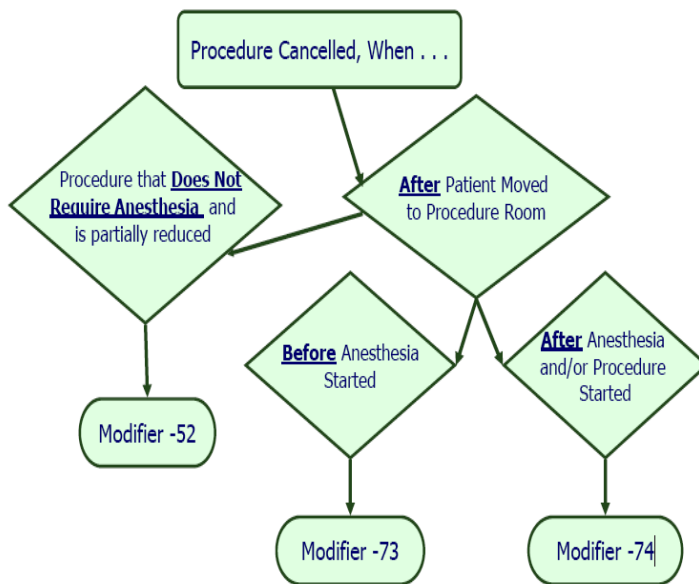
28

Modifier 73/74

- **When one or more of the planned procedures is completed, report the completed procedure <u>without</u> Modifier 73/74**

- **When none of the procedures that were planned were completed, report the first procedure with Modifier 73/74**

29

Discontinued Svs Decision Tree

30

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

31

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**

32

Modifier 59

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

33

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**

34

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/

35

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**

36

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.

continued
37

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

Column 1	Column 2	Effective Date	Deletion Date	Modifier
93015	93005	19960101	*	1
93016	93005	19960101	*	1
93017	93005	19960101	*	1
93018	93005	19960101	*	1
93025	93005	20021001	*	1
93278	93005	19960101	*	1

38

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**

39

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**

40

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

41

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

42

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)**
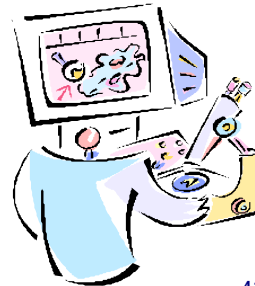
43

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**

44

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

45

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**
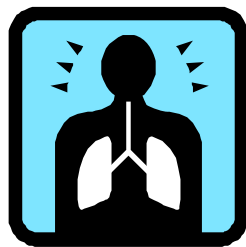
46

Modifiers 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

47

Modifiers LT and RT

- Identify procedures, which can be performed on paired organs

- Used when a procedure is performed on *only one* side

48

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**

49

Modifier 50

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

50

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.**

51

Modifier 50

- **73565**   **Bilateral knees standing**
- **73600-50**   **Ankle two views, done bilaterally**
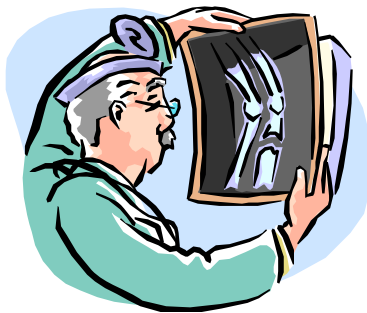
52

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**

53

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**

54

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**

55

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.

56

Modifier GG

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

57

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**

58

Modifier GH

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

59

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**

60

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**

61

Modifier TS

- **Append modifier to glucose screening tests (82947, 82950, 82951)**
- **Coverage and diagnosis coding requirements also apply**
- **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0660.pdf**

62

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**

63

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**

64

Modifier GA

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

65

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**

66

CPT® Codes Copyright 2007 by AMA. All Rights Reserved

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**

67

Modifier GN

- **Services delivered under an outpatient speech-language pathology plan of care**

  - **CPT/HCPCS codes billed under revenue code 44X**

68

Modifier GO

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

69

Modifier GP

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

70

Modifiers GN, GO, GP

- **Commonly hard-coded in the facility Chargemaster**

- **Required for services provided to Medicare beneficiaries**

71

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**

72

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**

73

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**

74

Modifier 58

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

75

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**

76

Modifier 78

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

77

Modifier 79

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

78

Modifier Coverage and Reimbursement

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

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

79

Modifier Coverage and Reimbursement

- **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**

80

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

81

Audience Questions

Audio Seminar Discussion

Following today's live seminar
Available to AHIMA members at
www.AHIMA.org

Click on Communities of Practice (CoP) – icon on top right
AHIMA Member ID number and password <u>required</u> – for members only

Join the <u>Coding Community</u> from your Personal Page
Under Community Discussions, choose the
Audio Seminar Forum

You will be able to:
- Discuss seminar topics
- Network with other AHIMA members
- Enhance your learning experience

AHIMA Audio Seminars

Visit our Web site
http://campus.AHIMA.org
for information on the
2008 seminar schedule.
While online, you can also register
for seminars or order CDs and
pre-recorded Webcasts of
past seminars.

AHIMA
Distance Education

Upcoming Seminars/Webinars

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

Thank you for joining us today!

**Remember – sign on to the
AHIMA Audio Seminars Web site
to complete your evaluation form
and receive your CE Certificate online at:**

http://campus.ahima.org/audio/2008seminars.html

**Each person seeking CE credit must complete the
sign-in form and evaluation in order to view and
print their CE certificate**

**Certificates will be awarded for
AHIMA Continuing Education Credit**

Appendix

Appendix

REVENUE IMPACT TABLE

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

AHIMA
Distance Education

To receive your

CE Certificate

Please go to the Web site

http://campus.ahima.org/audio/2008seminars.html
click on
"Complete Online Evaluation"

You will be automatically linked to the
CE certificate for this seminar <u>after</u> completing
the evaluation.

Each participant expecting to receive continuing education credit must complete the online evaluation and sign-in information after the seminar, in order to view and print the CE certificate.