Good afternoon everyone ! My name is Christine Andrews and I am an Education Specialist in the Provider Outreach and Education Department at Highmark Medicare Services. On behalf of my associates in Camp Hill, Timonium and Pittsburgh, we welcome you to the Highmark Medicare Services Lunch and Learn teleconference on Modifiers today, February 27, 2008.

This teleconference is being recorded and will be available as an MP3 download on the Highmark Medicare Services website in the same area where you received the teleconference materials.

The handouts for today's call have been posted to our website and hopefully you've all had a chance to download them.

Your handouts include:
The agenda, the slide presentation, modifier resources document, and the evaluation form.

We value your feedback, so at the end of the teleconference, please complete the evaluation and fax it to the number listed on the form.

We will be following the following agenda:

- When to Use Modifiers
- Modifier Issues
- Correct Coding Initiative (CCI)
- Medically Unlikely Edits (MUE)
- Resources

What is a modifier? CPT defines a modifier as a means to report or indicate that a service or procedure performed has been altered by some specific circumstance but has not changed the definition or the code. They also enable effective response to payment policy requirements established by other entities.

Examples of Level I and Level II Modifiers….not an all inclusive list are:

- Level I, CPT Modifiers
  25, 27, 50, 52, 58, 59, 73, 74, 76, 77, 78, 79, 91

- Level II, HCPCS Modifiers
  CA, CB, CC, CD, CE, CF, CR, E1, E2, E3, E4, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, GA, GG, GH, GN, GO, GP, GY, GZ, LC, LD, LT, QL, QM, RC, RT, TA, T1, T2, T3, T4, T5, T5, T7, T8, T9

Use of modifiers applies to services/procedures performed on the same calendar day. Remember, you do not use a modifier if the narrative definition of the code indicates multiple occurrences or that the procedure applies to different body parts. When it is appropriate to use a modifier, the most specific modifier should be used first. For example, when modifiers E1 through E4 apply, they should be used before the LT, RT, or 59 modifiers.

You should not submit claims without first reviewing your documentation to see if modifiers are needed for the procedures or services performed.

First we will talk about when to use modifiers and their definitions

Modifiers are necessary when correctly coding the services or procedures provided to your patients.

When do you use a modifier?

- When you need to indicate the anatomical site of a procedure performed,
- When you want to indicate what type of therapy a patient is receiving so it is applied to the therapy cap,
- To indicate you are billing a medically necessary therapy that is above the therapy cap, and
- To eliminate the appearance of unbundling.

Modifiers are used to enhance a code narrative, to describe the circumstances of each procedure or service, and how it individually applies to the patient.

Modifiers are essential to effective communications between you and Highmark Medicare Services. Modifiers DO NOT ensure reimbursement. Some modifiers may increase reimbursement but some are only informational.

There are dozens of modifiers but today we will focus on those, which are significant to you.

The AMA developed HCPCS Level I modifiers, which are numeric. They are found in the CPT manual. CMS developed the HCPCS Level II modifiers, which are alphabetic. They are used to explain various circumstances of procedures and/or services, and you can find the definitions for these modifiers.

Also, the CMS Internet Only Manual contains modifier information under specific topics.

Several HCPCS modifiers are used to signify a line item that is not covered or not payable by Medicare.

Also, to prevent Erroneous Denials – Duplicate CPT/HCPCS codes are billed to report separate procedures performed on different anatomical sites or different side of the body.

A modifier is added to the CPT/HCPCS code. You report the modifier next to the CPT/HCPCS code in field locator 44 on the UB-04.

The following modifiers are most frequently used:
25 – Separate identifiable E/M service
GP, GO, GN – for PT, OT and SLP
KX – medical necessity service above the therapy cap

LT/RT – left side/right side
GA – ABN signed by the patient prior to service performed
59 – Distinct procedural service, other than E/M (National Correct Coding Initiatives)

We'll discuss each one of these in more detail.

First we'll talk about the 25 modifier. CPT defines this modifier as a "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service." You would bill with a 25 modifier when a procedure and evaluation and management (E/M) are billed on the same day; a different diagnosis is not needed, and the documentation must support modifier use.

Before you decide to append the 25 modifier, there are some questions you should ask:
What was the purpose of the patient's visit? Why is this patient being seen and is there anything that would prompt a separate E/M service?
Does the documentation support an E/M over and above the usual work for the procedure?

Documentation is critical for these services. The documentation needs to clearly support the separate E/M service.

If a separately identifiable E/M service is provided on the same date that a diagnostic and/or therapeutic procedure(s) is performed, ensure the documentation substantiates the E/M service and the modifier 25.

Modifier –25 is appended only to E/M service codes. For outpatient services paid under OPPS, the relevant code ranges are:

99201-99215 (Office or Outpatient Services)
99281-99285 (Emergency Department Services)
99241-99245 (Office or Other Outpatient Consultations)

It is not necessary that the procedure and the E/M service be provided by the same physician/practitioner for the modifier –25 to apply in the facility setting. It is appropriate to append modifier –25 to the qualifying E/M service code whether or not the E/M and procedure were provided by the same professional.

The diagnosis associated with the E/M service does not need to be different than that for which the diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s) was provided.

It is appropriate to append modifier –25 to ED codes 99281-99285 when these services lead to a decision to perform diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s).

Modifiers LT / RT are used to identify services performed on the left /right side of the body.

Hospitals use the appropriate RT or LT modifier to identify which of the paired organs were operated on, indicating the side of the body the procedure or service was performed. These modifiers are required whenever they are appropriate.

- Do not use if the procedure code indicates multiple occurrences;
- Do not use if the procedure code indicates the procedure applies to different body parts; and
- Do not use if a more specific modifier is available

Modifier 59 is used to indicate that a procedure or service was distinct or independent from other services. This powerful modifier can be commonly misused if you are not careful. I'll cover some of the common issues to help you utilize this modifier correctly.

Multiple services provided to a patient on one day by the same provider may appear to be incorrectly coded, when, in fact, the services may have been performed as reported. Modifier 59 was established to permit claims of such a nature to bypass Correct Coding edits. The addition of this modifier to a procedure code indicates that the procedure represents a distinct procedure or service from others billed on the same date of service.

For therapists, modifier -59 can be used to indicate distinct procedures and the documentation must support it.

Clinical documentation must justify the use of the 59 modifier.

Modifier 59 is an important modifier associated with the National Correct Coding Initiative or NCCI.

NCCI was developed to promote correct coding and control improper payments from the Medicare program.

Procedures should be reported with the HCPCS or CPT codes that most comprehensively describe the services performed. This is commonly called "bundling".

Medicare uses NCCI "edits" to ensure that the most comprehensive codes are billed. NCCI edits are published on the internet and consist of two types: Column 1/Column 2 Codes and Mutually Exclusive Codes.

The edits define when two codes may not be reported together except under special circumstances. You use modifiers to report these circumstances and "bypass" the edit.

Typically, this is the modifier 59, but other modifiers can be used.

CCI edits will be applied on a date-of-service (DOS) basis.. These are the same CCI edits that have been applied to Outpatient Prospective Payment System (OPPS) hospital services (including PT, OT, and SLP services) since 2000.

CCI undergoes quarterly updates, generally on January 1, April 1, July 1, and October 1 of each year, may add new edits, delete edits that are no longer necessary, or modify edits. The website link is: http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp#TopOfPage

The column 1 code is the payable code and the column 2 code is in addition to the column 1 code There is a column with the effective date of the edit, and the last column gives the indicator that lets you know if it is acceptable to bill the code pairs with a modifier. The indicator 1 tells you that a modifier is allowed when billing that particular code pair. An indicator of zero tells you that a modifier is not allowed.
If a modifier is allowed, you would append it to the column 2 code.

The mutually exclusive table are codes that cannot reasonably be done in the same session. The instructions are the same as on the column 1/column 2 table, the code in Column 1 on the Mutually Exclusive Table is the payable code. The modifier information is the same.

CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE. You would bill with a modifier for reporting units of service in excess of MUE.

MUE was implemented January 1, 2007 and is utilized to adjudicate claims at Carriers, Fiscal Intermediaries, and DME MACs. The web addresses for further information on these edits are:
http://www.cms.hhs.gov/transmittals/downloads/R178PI.pdf
http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp

Modifier GA is used when the physician has provided a Medicare beneficiary with an Advanced Beneficiary Notice or ABN.

I'll define an ABN first, then discuss the modifier.

An advanced beneficiary notice or ABN is a written notice which you give to a Medicare beneficiary. The purpose of the ABN is to inform a beneficiary that Medicare probably will not pay for specific items or services on that occasion or date of service.

This notice allows the patient to make an informed decision whether or not to receive the items or services for which he or she might have to pay for out of pocket or through other insurance. It also protects you from liability when you believe that Medicare may deny a service as not reasonable and necessary or too frequent. Maintain the ABN in the patient's record and provide a cop to the patient.

When should you provide an ABN?

Whenever you provide a Medicare patient with a service that you know or could reasonably have known is not medically necessary, you are required to notify the patient in writing before performing the service.

You could issue an ABN for services which are frequency limited. The ABN should indicate the frequency limitation as the reason the service may deny.

You must advise the patient on why you expect Medicare to deny the service. The beneficiary, or their authorized representative must be able to comprehend the notice.

Without a properly signed ABN, a service that has denied due to medical necessity or frequency cannot be billed to the patient.

For more information on issuing ABNs, please reference the CMS Internet Only Manual, Publication 100-4, Chapter 30, Section 50 located at:
http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf
http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp#TopOfPage

You should not issue an ABN to a patient in the following circumstances:

- If you expect Medicare will pay for a service.
- On a routine basis.
- Beneficiary in a medical emergency or under great duress

You should never obtain a signature from a patient on a blank ABN and then complete it later. When I say routine, I mean that a physician or supplier should not give an ABN to a patient for no specific reason. This is considered a generic ABN. Giving an ABN for all services or claims is not an acceptable practice. This is considered a blanket ABN.

When the beneficiary has signed an ABN, you append Modifier GA to the service.
If the service denies as not medically necessary or too frequent, the patient will be liable for payment for the service.

You must submit a redetermination to add the modifier GA to a previously processed claim. You will need to provide a copy of the ABN with your redetermination request.
http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf 100-04 chapter 4 section 20.6 on modifiers.

GO, GP, and GN modifiers identify the type of therapy service being provided to your patient, according to their therapy plan of care. These should not be used with codes that are not on the list of applicable therapy services. You can find a listing of therapy codes on the CMS website in their IOM (Internet-Only Manuals), specifically Pub 100-4, chapter 5, section 20.
http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf

These codes with the GO, GP, and GN modifiers are also used to update the Common Working File for the therapy cap.

The KX modifier is billed when the beneficiary qualifies for a therapy cap exception and when the provider feels the beneficiary will exceed the therapy cap. Do not add the KX modifier to any service that is not a medically necessary service.

It is only appropriate to use a KX for a service that reasonably may exceed the cap.

And again, make sure that you utilize the resources that are available to you when billing your services to Medicare.

- Ensure the correct modifier is billed,
- Ensure your documentation supports the modifier that is billed, and
- Know the resources that are available to you (CPT, HCPCS)

Please utilize the customer contact center as well as the interactive voice response system (IVR) if you need assistance.

This concludes my presentation. Highmark Medicare Services would like to thank you for your participation in the "Modifiers" Lunch and Learn Teleconference. We encourage you to complete the evaluation form and fax it to the number listed on the form. We value and appreciate your feedback and comments and look forward to hearing from you.