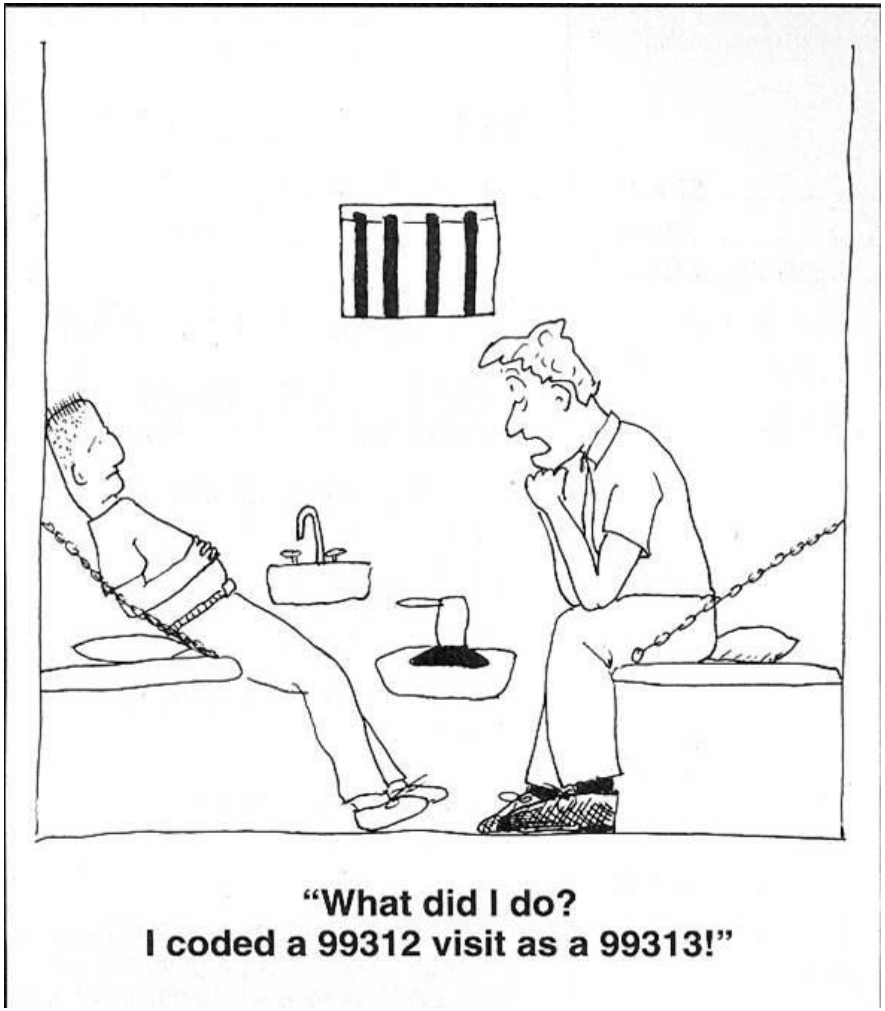
Back to Basics: Modifiers and Place of Service Codes

Lawrence A. Santi, DPM, FASPS
Member, APMA Coding Committee

BACK to BASICS

APMA American Podiatric Medical Association | CODING SEMINARS

Modifiers



- Modifiers are to be used when additional information would be beneficial to the insurance company and/or to the physician in order to get the claim paid in a timely manner.
- They are used as a two-digit shorthand to explain specific details about the patient encounter.
- Electronically you should now be able to append 4 possible modifiers per billed line.

E/M Modifier

- -21 Prolonged E&M Service
  - (Perform a higher level - i.e., 99203 but spend an hour with the patient and document face to face time with patient was over half the time)
- -24 Unrelated E/M during post-op period
  - CMS 1500 Block #19 put the reason why the E&M was unrelated and necessary

Compare -57 and -25

- -57
  - Decision for major surgery based upon the E/M done today
  - Major procedure for Medicare/Medicaid
  - Any procedure for commercial insurance
- -25
  - Separately and identifiable E/M service on same day as a minor surgical procedure
  - Document your E&M well and keep any procedure documentation as a separate part of your note
  - Used with minor procedure for Medicare or for commercial insurance

Modifier -25 Note Example

- S= C/C HPI ROS
- O= Objective Findings
- A= Diagnoses
- P= Counseling (face-to-face patient time), tests ordered, reviewed other reports
- Procedure: Separate paragraph or line item relating the procedure that you performed. Some examples include: injections, ulcer debridement, destruction of verruca or nail procedure.

Procedure Modifiers

- -22 Unusual Procedural Service (requests a higher payment, always involves hand processing, must include documentation stating how the service exceeds usual and customary)
- - 76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional (2011 Revised)
- -77 Repeat Procedure or Service by Another Physician or Other Qualified Health Care Professional (2011 Revised)

Procedure Modifiers

- -78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period (2011 Revised)
- -79 Unrelated procedure by same physician during post-op period

Unusual Circumstances Modifiers

- -52 Reduced Services
- -53 Discontinued Procedure after anesthesia
  - V64.1 discontinued due to contraindications
  - V64.2 discontinued due to patient decision
- -54 Surgical Care Only (someone else providing care)
- -55 Postoperative Management Only

Unusual Circumstances Modifiers

- -73 Discontinued Outpatient Hospital / ASC Procedure prior to administration of anesthesia
- -74 Discontinued Outpatient Hospital / ASC Procedure after administration of anesthesia

Unusual Circumstances Modifiers

- -50 *Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code. (Revised 2011)*
  - Example - (perform hammertoe correction 2nd bilaterally: 28285-50-T1-T6, make sure you charge 1.5x - 2x your normal fee)

Unusual Circumstances Modifiers

- -51 Multiple procedures (many insurances, such as Medicare, electronically add this to certain CPT codes and they ask that you do not append this modifier)
- -58 Staged procedure (example: applying a skin substitute weekly for coverage you must do: 15365-58)
- -59 Distinct procedural service when no other modifier will suffice. Always use a more specific modifier if you can.

-59 modifier

- The “-59” modifier unbundles (as well as the “-25” modifier as well as the new “X” modifiers) CCI or other global bundling edits
- The documentation must clearly evidence that the procedure or service was comprehensive, and not a component of another billed procedure

-59 modifier

- The “-59” modifier is defined as “unbundling”
  - Different sessions
  - Different procedures
  - Different site or organ system
  - Separate incision or excision
  - Separate lesion
  - Separate injury (or area of injury) not performed on the same day by the same individual

-59 modifier

- “Currently, providers can use the -59 modifier to indicate that a code represents a service that is separate and distinct from another service with which it would usually be considered to be bundled.
- Because it can be so broadly applied, some providers incorrectly consider it to be the ‘modifier to use to bypass National Correct Coding Initiative (NCCI)’, it is the most widely used modifier.
- It is also associated with considerable abuse and high levels of manual audit activity, leading to reviews, appeals and even civil fraud and abuse cases.

-X(EPSU) vs -59 MODIFIER

- Modifier- XE
  - Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter

- Modifier –XS
  - Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure

-X(EPSU) vs -59 MODIFIER

- Modifier –XP
  - Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner

- Modifier –XU
  - Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

-59 and the -X

- The “-59” modifier is defined as “unbundling”
  - Different sessions (-XE)
  - Different procedures (-XU)
  - Different site or organ system (-XS)
  - Separate incision or excision (-XS)
  - Separate lesion (-XS)
  - Separate injury (or area of injury) not performed on the same day by the same individual (-XP)

-59 and the -X

- “CMS will not stop recognizing the -59 modifier but notes that CPT instructions state that the -59 modifier should not be used when a more descriptive modifier is available.
- CMS will continue to recognize the -59 modifier in many instances but may selectively require a more specific - X{EPSU} modifier for billing certain codes at high risk for incorrect billing

-XP

- -XP, Separate Practitioner: A service that is distinct because it was performed by a different practitioner.
- *Example*: It's a little unclear, but probable use is in a scenario like this: The patient is seen by one provider who in the course of treating a patient encounters a problem outside his scope of ability so calls in another doctor to perform the service

-XE

- -XE, Separate Encounter: A service that is distinct because it occurred during a separate encounter.
- *Example*: If a patient came in for an outpatient EKG, then comes back later in the day for blood work, the blood work would require an XE modifier.

-XS

- **XS, Separate Structure:** A service that is distinct because it was performed on a separate organ/structure.
- *Example:* If a wound is repaired on a patient's arm, but there is also a wound on the leg, the coding would represent the arm wound and the legal wound, with the modifier XS after the leg wound code.

-XU

- XU, Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.
- *Example:* A diagnostic procedure is performed. Due to the findings, a decision is then made to perform a therapeutic/surgical procedure. (This may or may not occur in the same procedure room during the same session/encounter.)

X marks the spot (where we start auditing)

- The most applicable modifiers for podiatric care will likely come down to the decision to either use -59 or –XS. Only the proper modifier will be paid and you cannot use both.

- X designed to circumvent the “improper use of the -59 modifier”

Medicare Modifiers

- A1 Dressing for one wound
- A2 Dressing for two wounds
- A3 Dressing for three wounds
- A4 Dressing for four wounds
- A5 Dressing for five wounds
- A6 Dressing for six wounds
- A7 Dressing for seven wounds
- A8 Dressing for eight wounds
- A9 Dressing for nine or more wounds

Medicare Modifiers

- GA Waiver of liability statement (ABN) on file with ABN waiver signed
- GY Item or service statutorily non-covered; No need to get ABN waiver
- GZ Item or service expected to be denied as not reasonable and necessary

Wound Care Code Modifiers

- Check Medicare LCD for specific use for:
  - KX modifier (Skin substitute products and their application procedures for which the skin substitute was handled, applied, and immobilized appropriately and according to manufacturers' label instructions)
  - JC (Report skin substitute products used as a skin graft
  - JD (Report skin substitute products not used as a skin graft)
  - JW (Product wasted - discarded)

DME Modifiers

- KX Specific required documentation on file
- EY No physician or other licensed health care provider order for this item or service (items billed to the DME MAC before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code)
- NU New equipment

HCPCS Modifiers

- GJ“OPT OUT” physician providing emergency/urgent care
- GP Services were provided under an outpatient physical therapy plan of care
- GW Service not related to hospice patient’s terminal care (used when a hospice patient is seen, but services are unrelated to the terminal condition)

HCPCS Modifiers

- AQ (replaced QB ad QU) Physician services provided in health provider shortage area (HPSA)
- QW CLIA waived test

HCPCS Modifiers

- -LT Left foot
- -TA Left great toe
- -T1 2nd toe, left foot
- -T2 3rd toe, left foot
- -T3 4th toe, left foot
- -T4 5th toe, left foot

-RT Right foot
-T5 Right great toe
-T6 2nd toe, right foot
-T7 3rd toe, right foot
-T8 4th toe, right foot
-T9 5th toe, right foot

HCPCS Modifiers

- Q5 Service provided by substitute physician under reciprocal billing arrangement

- Q6 Services provided by a locum tenens physician

HCPCS Modifiers

- -AS Assistant at Surgery of a physician assistant, nurse practitioner or clinical nurse practitioner
- -GC Service performed in part by resident under direction of teaching physician (informational only)
- -GE Service performed by a resident without the presence of a teaching physician [primary care exception] (informational only)

HCPCS Modifiers

- Q7 One Class A finding
- Q8 Two Class B findings
- Q9 One Class B and Two Class C findings

Place of Service Cheat Sheet

- 04 = Homeless Shelter
- 05 = Indian Service Free Standing Facility
- 11 = Office
- 12 = Home
- 13 = Assisted Living
- 14 = Group Home
- 20 = Urgent Care Facility
- 21 = Inpatient Hospital
- 22 = Outpatient Hospital
- 23 = Emergency Room – Hospital
- 24 = Ambulatory Surgical Center
- 25 = Birthing Center
- 26= Military treatment Facility
- 31 = Skilled Nursing Facility
- 32 = Nursing Facility
- 33 = Custodial Care
- 34 = Hospice
- 54 = Intermediate Care Facility/Mentally Retarded
- 55 = Residential Substance Abuse Treatment Facility
- 56 = Psychiatric Residential Treatment Center
- 61 = Comprehensive Inpatient Rehab Facility
- 62 = Comprehensive Outpatient Rehab Facility
- 72 = Rural Health Clinic
- 99 = Other Place of Service Not Listed

Questions?