



COMMUNITY HEALTH PLAN
of Washington

Committed to your health.®



Provider Education Webinars

Course 6:

Utilizing CPT & HCPCS Modifiers

Housekeeping Items

Technical Difficulties

If you experience technical difficulties, please

- utilize the “Chat” feature of the GoToWebinar application to let us know what kind of problem you’re having
- exit the application and try re-establishing your internet and phone connections
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Webinar Questions

For questions concerning the content of this webinar, CHP has a dedicated email address: providereducation@chpw.org.

Questions about Specific Coding Scenarios

If you have questions about particular documentation and coding questions (specific coding scenarios) please email it to us at providereducation@chpw.org.

Questions about Claims

If you have questions about specific coding/claims processing issues, please use your usual route for claims queries (the webinar project isn’t set up to be the best forum to access claims information).

Continuing Education Credit

At the end of each webinar, there are instructions detailing how to request Continuing Medical Education and/or Continuing Education Units, by using the dedicated email address that CHP has established for this activity: providereducation@chpw.org.

Welcome

Welcome to this presentation of Community Health Plan's Provider Education Webinar, Course 6: Utilizing CPT & HCPCS Modifiers

This webinar series is designed specifically for Community Health Plan's Physicians, Healthcare Professionals, and Administrative Staff who want to broaden their understanding and use of documentation and coding skills.

This webinar series consists of 10 one-hour courses.

Attendees may earn

- Continuing Medical Education (CME) through the AAFP*, and/or
- Continuing Education Units (CEU) through AAPC** and AHIMA***

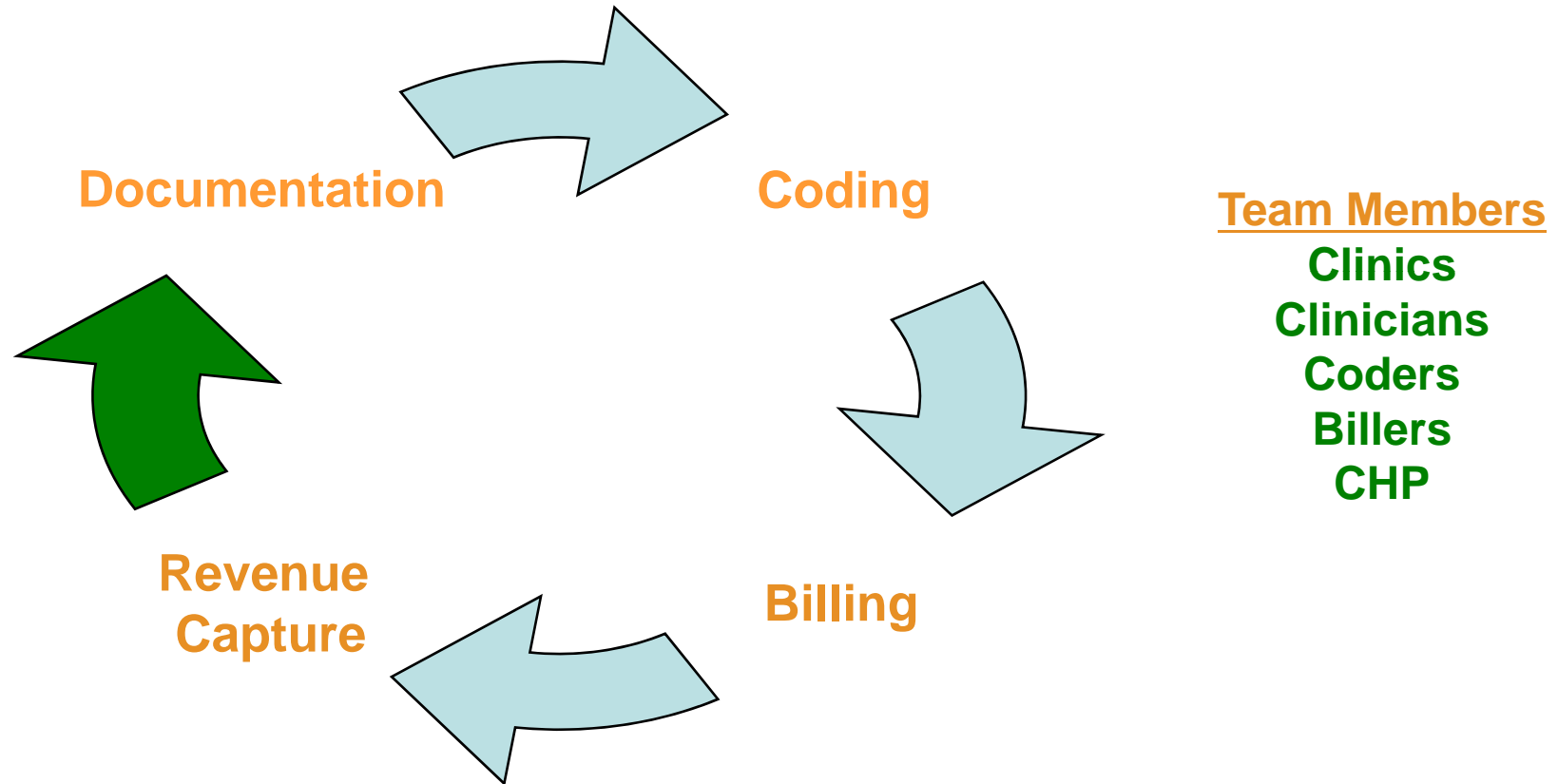
Courses and Self-Assessments must be completed to earn the CME/CEU credit.

* American Academy of Family Physicians

** American Academy of Professional Coders

*** American Health Information Management Association

A Comprehensive Approach to Optimizing Documentation & Coding



Our Role – Clinical Components

- Deliver timely comprehensive care....
- Document the care you deliver....
- Code the care you document....
- Capture the codes you document...

Community Health Plan - Medicare Advantage
Member HCC Report



HEALTH CENTER - Clinic Name

Run Date: 10/27/2008

Patient Name: Doe, John
 Address: 1234 Main Street, Anytown, US 98765
 Phone: (555) 555-5555

Member ID: HP1000000000

How To Use This Report

Step 1: Please review the diagnoses (ICD9 codes) and conditions (Hierarchical Condition Categories (HCC Codes)) listed in Sections 1 and 2. If you believe that a diagnosis/condition listed here is not relevant to this patient, please circle the diagnosis/condition.

Step 2: After reviewing, please sign below and fax this form to our confidential fax: 206-652-7024, Attn: Member HCC Report.

Step 3: At your next visit with this patient, please check for the presence of these diagnoses/conditions and document each currently present diagnosis/condition accordingly in your visit note.

Section 1 - Conditions (HCCs) Reported in Current Year

(Reported diagnoses may come from multiple care settings, including primary care, specialty care and hospital providers. Only one HCC per patient is shown, with highest documented ICD9 code.)

ICD9 Code	ICD9 Description	HCC Code	HCC Description	Risk Score
250.00	Dmii Wo Cmp Nt St Uncntr	19	Diabetes without Complication	0.2

Section 2 - Additional Conditions (HCCs) Reported in Prior Years

ICD9 Code	ICD9 Description	HCC Code	HCC Description	Risk Score
291.81	Alcohol Withdrawal	51	Drug/Alcohol Psychosis	0.353
303.90	Alcoh Dep Nec/Nos-Unspec	52	Drug/Alcohol Dependence	0.265
780.39	Convulsions Nec	74	Seizure Disorders and Convulsions	0.269
428.0	Chf Nos	80	Congestive Heart Failure	0.417
		16	Diabetes with Neurologic or Other Specified Manifestation	0.552
		71	Polyneuropathy	0.268

I have reviewed the diagnoses/conditions listed on this page, along with the medical history of this patient. With the exception of those codes that are circled, I attest that these diagnoses/conditions are present in this patient's medical history as available to me beginning _____ (mm/yyyy).

 Printed Name & Credentials

 Signature

 Date

Community Health Plan of Washington Provider Education Webinar

Course 6: Utilizing CPT & HCPCS Modifiers

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Cost Recovery Analyst

Learning Objectives

Webinar Learning Objective:

The goal of Community Health Plan is that our Providers will apply this career training and best practices information across their care spectrum, regardless of their Patients' ability to pay or insurance type.

Course 6 Utilizing CPT& HCPCS Modifiers Learning Objective:

To focus on proper use of CPT & HCPCS modifiers to meet various coding and descriptive requirements.

Participants' learning objectives for Course 6:

- Understand the purpose of CPT and HCPCS Modifiers
- Learn which CPT Modifiers impact reimbursement
- Recognize how the proper use of modifiers improves documentation quality, coding accuracy, and ethical revenue.

The Common Procedural Terminology (CPT) Modifiers : Definition and Purpose

Modifier Definition:

“A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.”

Modifier Purpose:

The CPT code provides a uniform language that accurately describes medical, surgical, and diagnostic services and serves as a effective means for nationwide communication among Providers, Payers, Public Health Researchers, Government Agencies, and Patients.

2009 CPT Coding Manual, American Medical Association

Why Modifiers Are Essential

Modifiers are appended to CPT and/or HCPCS codes to enhance a code description.

Proper use of modifiers:

- Precisely describes the service performed in relation to the published service description
- Provides additional information and is even mandatory on some services
- Indicates circumstances or conditions of patient care
- Demonstrates repeat or multiple procedures
- Establishes cause for higher or lower cost
- Conveys a particular component of a procedure, such as the professional component or technical component
- Describes services such as assistant surgeon services, so that proper utilization and payment can be determined

Example: What Modifiers Accomplish

Reporting a certain type of toenail removal procedure

Without a modifier:

CPT code 11730 (standing alone) describes:

Avulsion of nail plate, partial or complete, simple; single

With a modifier:

CPT code 11730 with **-T2** modifier appended describes:

Avulsion of nail plate, partial or complete, simple; single, **left foot, third digit**

Modifiers: Listing Location & Occurring Changes

Where to look for a complete listing of CPT modifiers:

Appendix A of the AMA's CPT manual

Why to look at the complete and current listing regularly:

Modifiers are updated regularly: some deleted, some added, some revised.

A recent change:

Modifier 21 Prolonged E&M Services was deleted.

New CPT codes were added to describe these services more precisely than the modifier did. Using Modifier 21 for services performed after the effective date of the change resulted in denials of claims for those services.

National Correct Coding Initiative Edits (NCCI Edits)

The NCCI Edit Listing is a comprehensive listing of component codes that may and may not be used together, by listing mutually exclusive coding combinations.

The listing is available at:

www.cms.hhs.gov/nationalcorrectcodinitd/01_overview.asp

- Column I – lists the primary code
- Column II – lists codes which are bundled into the Column I code
- Last column of the CCI is the “Modifier Indicator”
 - 1 –can use modifier 59 or other CCI modifier on Column II code
 - 0 –not allowed
 - 9 –not applicable

To address concerns about specific NCCI edits, submit them in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907

Attention: Niles R. Rosen, M.D., Medical Director and Linda S. Dietz, RHIA, CCS, CCS-P,
Coding Specialist

Fax #: 317-571-1745

CPT Global Package Days

The Centers for Medicare and Medicaid Services (CMS) has established global periods in the form of follow-up days included in certain surgical procedure codes.

These global periods are published in the Federal Register, and these officially assigned global periods can consist of 0 days, 10 days, or 90 days. Minor procedures (such as minor laceration repair) are assigned shorter periods, and major procedures (such as hysterectomy) are assigned longer periods.

Value Descriptions

000	Endoscopic or minor procedure which includes an Evaluation and Management service on the same day of the procedure.
010	Minor procedure including 10 days of routine follow-up post op care.
090	Major procedure including 90 post op care days.
MMM	Maternity codes. Global period concept does not apply.
XXX	Global concept does not apply.
YYY	Carrier determines the length of the global period.
ZZZ	Related to another service, and falls within the global period of the other service.

Modifier 22 Unusual Procedural Service + Modifier 59 Distinct Procedural Service

Example:

A 4 year old male patient was treated for laceration of the left foot. He was playing outside at home and stepped on a piece of glass. Glass was embedded in the left foot as well as splinters of glass in both feet. The child cried constantly and couldn't be calmed.

X-ray revealed a small radiopaque foreign body in the child's left foot.

Child was papoose. Plain xylocaine was used as a local anesthetic. Left foot was incised. Glass was removed.

Foreign body was deep and removal complicated (28193-22) with bleeders encountered and cauterized. Removal of glass splinters from both feet was time consuming and tedious. Procedure is significantly prolonged due to the multiple slivers, dirt and gravel in the wounds requiring partial skin thickness debridement (11040-59) and cleaning. Procedure normally takes 45 minutes: I spent over 2 hours . Patient sent home with Mother with RXs for analgesic and antibiotic.

Report CPT codes 28193-22 and 11040-59

CMS Modifier 22 Explanation form:

https://www.noridianmedicare.com/p-meddb/forms/mr_forms/29309795_nas_mod_22_form.pdf

CMS Modifier 22 Explanation Form

https://www.noridianmedicare.com/p-medb/forms/mr_forms/29309795_nas_mod_22_form.pdf



Modifier 22 Explanation Form

When you use Modifier 22, you are claiming that the procedure required an unusual amount of time and effort, beyond the "difficult" case. To help our medical staff effectively review this claim, please fill out this form and submit it with a copy of your operative report, if the operative report does not contain the reason for the use of modifier 22 and you have been asked by Medicare to submit this documentation.

For all modifier 22 claims, the operative report must be submitted when requested via a letter. If the operative report has a paragraph clearly labeled "Unusual Procedure", this will be all that is required. If there is no such clearly labeled description, then this form or a separate letter will be required for the claim to be considered for additional payment.

Do not use generalized statements such as: "Surgery took an extra two hours", "Patient was very ill", or "This was a difficult surgery". These statements do not explain why the surgery was unusual.

Provider Name:

Provider Transaction Number (PTAN):

National Provider Identifier (NPI):

Patient Name:

Patient's Health Insurance Claim Number (HIC):

Patient's Date of Birth (DOB):

Date of Surgery:

Length of Surgery (operative time):

Unusual circumstances during the surgery that may warrant additional reimbursement:

Signature **Date**

Applies to the states of: WA, OR, & AK
Source: Medicare Claims Processing Manual, Chapter 12, Section 40.2 ~ Unusual Circumstances.

20100114 (0810) 0-01

Modifier 24 –Unrelated E&M Service During a Post-op Period of a Major/Minor Surgical Procedure

Report modifier 24 when an unrelated Evaluation & Management (E/M) service is done by the same physician during a postoperative period
The key here is the word *unrelated*.

Minor surgery is 0 or 10 days global period

Major surgery is 90 days global period

Append modifier 24 to the E&M code range only

Example:

Dr. Jones treats Mr. Smith for closed treatment of a dislocated shoulder on March 1st. (CPT code 23655 has a 90 day global period.)

On April 3rd, Mr. Smith again sees Dr. Jones in the office for management of his diabetes. Assuming the chart documentation supports it, report a 99213 with modifier 24.

Modifier 25 – Significant, Separately Identifiable Evaluation & Management Service By The Same Physician On The Same Day Of The Procedure Or Other Service

Example:

An established patient presents with a 1.5 cm laceration of the left index finger. During the visit to repair the laceration, this otherwise healthy patient complains of new edema in his left leg and ankle. An Expanded Problem-focused history and exam with low complexity medical decision making was performed in addition to the repair procedure.

Report:

CPT Code 12001

linked to:

ICD-9-CM diagnosis code
883.0 open wound finger

Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

AND

CPT code 99213-**25**

linked to:

ICD-9-CM diagnosis code
782.3 edema

Office or other outpatient visit for the evaluation
And management of an established patient, which
Requires at least 2 of these 3 key components:
EPF History, EPF Exam, and Low MDM

Modifier 50 Bilateral Procedure

Modifier 50 is used when a “unilateral” procedure is performed bilaterally.

Bilateral surgeries are procedures which are performed on both sides of the body during the same operative session or the same day.

Only use modifier 50 if the published code description (the code ‘descriptor’) does not identify the code as bilateral

Surgery performed on both sides of the body at the same operative session or on the same day

Refer to the Medicare Physician Fee Schedule at:

<http://www.cms.hhs.gov/PFSlookup/>

to determine whether the bilateral procedure concept applies to a particular procedure code.

Bilateral Surgery Indicator List

Bilateral Indicator Listing

- 0 – Bilateral surgery rules do not apply. Do not use 50 modifier.
- 1 – Bilateral surgery rules apply (150%). Use 50 modifier if bilateral. Units = 1.
- 2 – Bilateral surgery rules do not apply. Already priced as bilateral. Do not use 50 modifier. Units = 1.
- 3 – Bilateral surgery rules do not apply. Do not use 50 modifier. Units = 1 or 2.
- 9 – Bilateral surgery concept does not apply.

Bilateral Surgery Indicator Listing: <http://www.cms.hhs.gov/pfslookup/>

51 – Multiple procedures on the same day

Example

A patient presents to the clinic with a 1.5-cm laceration of the eyebrow, and the physician performs a simple repair (12011). The patient also has a 2.0-cm hand laceration that requires a simple repair. (12001-51)

Multiple Procedures	
51 – Multiple procedures on the same day	
0	Multiple surgery rules do not apply, do not use Modifier 51
2	Multiple surgery rules apply (payment is 100 %, 50 % 50 % etc.)
3	Special endoscopy rules apply if billed with another endoscopy
4	Subject to 25% reduction of TC – diagnostic imaging effective January 01 2006 and after
5	Multiple surgery concept does not apply

Multiple Procedures Indicator Listing :

<https://www.noridianmedicare.com/eula.php?t=/p-meddb/fees/index.html%3f>

Modifier 52 Reduced Services

Modifier 52 – Partially reduced or eliminated services is used when the service is reduced: the Physician didn't perform the service to the complete description as listed in the CPT manual.

Example

An established 41-yr old female patient presented for a preventive exam. Medical, family, and social history was reviewed, and a complete review of systems was documented. A detail physical exam was performed, and the patient deferred the pelvic and breast examination and pap smear. Counseling was provided regarding diet and exercise, substance abuse, sexual safety, and dental health. Risk factors were identified and interventions were discussed. Appropriate lab test were ordered.

Report 99396-52 because the service didn't include a portion of the CPT 99396 description: age and gender appropriate exam.

Modifier 53 –Discontinued Procedure

53 –Discontinued Procedure

Due to extenuating circumstances

Situations that threaten the health of patient

Not used for elective cancellation of procedure

Payment determined by report.

Example

A patient was in the operating room for a diagnostic arthroscopy of the knee. The physician inserted the arthroscope and the patient suddenly went into respiratory distress. The arthroscope was withdrawn and the procedure was terminated.

Modifiers 54, 55, and 56
Preoperative, Operative, & Postoperative Care ONLY

- 54 Surgery care only; Surgeon is performing only the preoperative and intra-operative care.

- 55 Postoperative management only;
Physician,
other than the surgeon,
assumes all or part of postoperative care.

- 56 Preoperative Management only:
Physician,
other than the surgeon,
assumes all or part of preoperative care.

Modifier 57 Examples

57 – Decision for surgery

E/M service resulting in the initial decision to perform major surgery.

Use only when surgical code has a 90 day global period.

E&M day before surgery

E&M day of surgery

Example:

Mr. White visits Dr. Jones due to some significant lower abdominal pain that began just recently. (99214-57) After an exam of the patient, Dr. Jones diagnoses Mr. White with acute appendicitis and performs an appendectomy (44950 has a 90 day global period) later that day.

Modifier 58 Staged or Related Procedure/Service by Same Physician During Post-op

- Modifier 58 Staged or Related Procedure/Service by Same Physician During Post-op
- Must be planned at time of original procedure.
- Must be more extensive than original procedure
- A therapeutic surgical procedure following a diagnostic surgical procedure
- Cannot be used to report the treatment of a problem that required a return to operating room

Example

Open incisional breast biopsy (19101 has a 10 day global period) performed on 2/10/09 the patient returns to the operating room within the postoperative period of the initial procedure for a more extensive removal of breast tissue. A modified radical mastectomy (19307- 58 has a 90 day global period) was performed on 02/17/09 7 days later for breast cancer.

59 Distinct Procedural Service

59 – Distinct procedural service on the same date of service by same physician

- Different anatomical sites
- Different sides of the body
- Different procedure, or
- Different session
- Do not use with 99419 - 99499 or 99201 – 99499

Example

Patient presents for removal of 13 skin tags (11200) during the same session the physician performed biopsies on two small lesions on the neck. (report 11100-59 single lesion and add on code 11101 for the additional lesion)

<http://www.cms.hhs.gov/NationalCorrectCodingEd/>.

Reporting Modifiers 51 & 59 Together Is Redundant

It's redundant to use Modifier 51 and 59 together.

Modifier 51 is used when you do two separate procedures at the same time.

Modifier 59 is used when the two procedures might normally be bundled.

Modifier 76: Repeat Procedure & Modifier 77: Repeat Procedure By Another Physician

76 – Repeat procedure by same physician

Procedure was repeated subsequent to original service

Add modifier to repeated service

Repeat procedures on same day

Can be used for x-rays and Injections

77 – Repeat procedure by another physician

Add modifier 77 for repeated service

Can also be used for x-rays and injections

79 Unrelated procedure by the same physician during a post-operative period

79 –is used when the procedure or service is unrelated to a procedure during the post operative period.

Use of modifier 79 is restricted to the same provider.

For Medicare patients a new global period begins with modifier 79

For Medicare patients & other payers when procedures are performed on the right and left sides of the body (same procedure) at different operative sessions during the postoperative period modifier RT or LT is used with modifier 79

Professional and Technical Components

Diagnostic tests can be billed as:

A Global Service performed both the technical and professional component. The physician's office performed an x-ray of the shoulder (one view) Report CPT code 73020 No modifier required.

Modifier 26 Professional Component Only.

Example:

The physician's office performed an x-ray of the shoulder (one view) but sent the film out to be read by a radiologist. The Radiologist reports CPT code 73020-26 to indicate the Radiologist performed the interpretation component only.

Modifier TC - Technical Component Only.

Example:

The office performed an x-ray of the shoulder (one view) but sent the film out to Be read by a Radiologist. Report CPT code 73020-TC for the Radiologic examination, shoulder; one view. Reporting the TC modifier further clarifies the provider performed the technical component only.

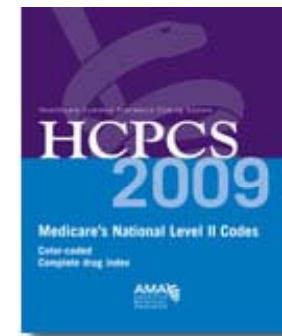
Health Care Procedure Coding System (HCPCS) Modifiers Definition and Purpose

Definition

- A modifier provides the means by which the health care professional can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

HCPCS modifiers may be used to indicate the following:

- Level II National Codes are alphanumeric codes
- Starting with a letter followed by four numbers
- HCPCS National Level II Modifiers



HCPCS Modifiers

Left & Right Modifiers

Left and Right Modifiers are informational only and have no effect on reimbursement.

- Modifier LT is used to identify procedures performed on the Left side of the body.
- Modifier RT is used to identify procedures performed on the Right side of the body.

HCPCS Modifiers

These HCPCS modifiers are used to identify services performed on the fingers and toes.

Right Hand

- F5 –Right hand, thumb
- F6 –Right hand, second digit
- F7 –Right hand, third digit
- F8 –Right hand, fourth digit
- F9 –Right hand, fifth digit

Right Foot

- T5 –Right foot, great toe
- T6 –Right foot, second digit
- T7 –Right foot, third digit
- T8 –Right foot, fourth digit
- T9 –Right foot, fifth digit

Left Hand

- FA –Left hand, thumb
- F1 –Left hand, second digit
- F2 –Left hand, third digit
- F3 –Left hand, fourth digit
- F4 –Left hand, fifth digit

Left Foot

- TA –Left foot, great toe
- T1 –Left foot, second digit
- T2 –Left foot, third digit
- T3 –Left foot, fourth digit
- T4 –Left foot, fifth digit

HCPCS Modifiers GA, GY & GZ: Advance Beneficiary Notice (ABN) Modifiers

Modifier GA should be used when Providers of services or supplies want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have obtained an ABN signed by the Medicare Beneficiary.

Modifier GY should be used when Providers of services or supplies want to indicate that the item or service is statutorily non-covered, or is not a Medicare benefit.

Modifier GZ should be used when Providers of services or supplies want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not obtained an ABN signed by the Medicare Beneficiary.

Modifier Resources

- 2009 CPT Coding Manual
 - Appendix A Contains CPT Modifiers and Descriptions
- 2009 HCPCS Coding Manual
- List of all HCPCS Modifiers
- Brief Description
- National Correct Coding Initiative
- www.cms.hhs.gov/nationalcorrectcodinitied
- Links to edits
- NCCI Manual
- Physician Fee Schedule Look-up Tool
- <http://www.cms.hhs.gov/PfsLookup/>
- “Payment Policies Indicators” are the guidelines that address if it is appropriate to use certain modifiers with that procedure code

Modifier Grid

<http://www.accuchecker.com/AccuLibrary/Articles/modifiergrid.asp>

Building a Bridge, and Using it

Ethical Responsibility

Guessing about where to find rules that apply to documentation and coding questions is not necessary, is unethical, and wastes your valuable time and energy.

CHP is here to help you build a foundation for understanding this valuable career skill, and to assist you with official references when questions about proper documentation and coding arise.

Feedback about the Webinar

Community Health Plan chose this enterprise-wide, long-term approach of online training to serve our Providers, achieve our training objectives, and optimize the delivery of this information (which ultimately benefits the Patients, the Providers, and the Plan).

To that end, CHP has created a dedicated email address for our Providers and their Staff to send questions and comments about this training: please email us at: providereducation@chpw.org. CHP encourages our Providers to give us feedback about this educational webinar, so that it may be continuously improved.

Continuing Education Credit Requirements

CHP has arranged to award CMEs (through AAFP) and CEUs (through AAPC and AHIMA) for Participants who:

- attend this webinar
- are counted as present
- complete a brief Self-Assessment and Quality Survey at the end of the webinar
- request the continuing, education credit in the manner described in the steps in the next slide.

Obtaining Continuing Education Credits

1. Send an email to providereducation@chpw.org with “Continuing Education Credit Request” in the subject line.
2. Be sure to let us know which organization/s you’re requesting continuing education credit from, and
3. Include your contact information in the body of the email.
4. A *brief* Self-Assessment will be emailed to requesters. The brief Self-Assessment is evidence of learning objectives met (and is a requirement of the continuing education granting organizations), and
5. Upon completion of your Self-Assessment, email it back to CHP at the above email address.
6. CHP will process and send the continuing education certificates to the Participants at the contact information provided in Step 3 (above).
7. As always, it’s the responsibility of the Participant to submit and/or make available proof of continuing education credit earned (CME/CEU certificates) to the AAFP, AAPC, and AHIMA on demand. CHP doesn’t submit certificates to these organizations on behalf of webinar Attendees.

Additional Resources: much of the information in the Webinar is available in a more comprehensive form at CMS’s website: <http://www.cms.hhs.gov/MLNGenInfo/> and click on the Web-Based Training Modules. There are additional CMS web-based training courses there as well.

Thank You for Participating

Community Health Plan would like to thank you for taking time out of your busy schedule to participate in today's Provider Education Course 6 Webinar: Utilizing CPT & HCPC Modifiers.

Community Health Plan has arranged for documentation and coding resources to be made available to you by email for questions about the materials covered in this webinar series. Send an email to providereducation@chpw.org with "Continuing Education Credit Request" in the subject line.

We cannot address specific, individual claims processing queries. There are other resources available for reimbursement questions, and the usual route for claims questions should be used for them.

The Provider Education Team is looking forward to delivering the next course in this webinar series, and it will reinforce the concepts and complement the content of this course.