1 □ **Modifiers-**
The Good, The Bad, The Audited
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2 □ **Disclaimers for Presentation**
1. All information was current at time it was prepared
2. Drawn from national policies, with links included in the presentation for your use
3. Prepared as a tool to assist doctors and staff and is not intended to grant rights or impose obligations
4. Prepared and presented carefully to ensure the information is accurate, current and relevant
5. No conflicts of interest exist for presenters- financial or otherwise. However, both Rebecca and Harvey write for Optometric Journals and Rebecca consults with Eye Care Centers OD PA.

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6. Of course the ultimate responsibility for the correct submission of claims and compliance with provider contracts lies with the provider of services

7. AOA, AOA-TPC, Optometry’s Meeting, its presenters, agents, and staff make no representation, warranty, or guarantee that this presentation and/or its contents are error-free and will bear no responsibility or liability for the results or consequences of the information contained herein

8. The content of the COPE Accredited CE activity was prepared with assistance from Kara Webb (AOA Staff) and Doug Morrow OD

9. 

4 □ **What Do They Do?**
• Modify the code description without changing the CPT code meaning
• Provide additional information regarding the service provided
• Tells the “story” clearly
• Integral part of CPT and HCPCS coding system
5 □ **Modifiers Can Indicate**
   • A service has been altered in some way
   • A service or procedure has both a professional and technical component
   • A service was performed by more than one provider
   • A service has been increased or reduced
   • An adjunctive service was performed

6 □ **Modifiers Can Indicate**
   • Part of a procedure was performed
   • A bilateral procedure was performed
   • A service or procedure was provided more than one
   • Unusual events occurred during the procedure

7 □ **Three Levels**
   • CPT Level I Modifiers
     – AMA CPT Manual Appendix A
   • HCPCS Level II Modifiers
     – HCPCS Book or federal Register
   • CPT Category II Codes
     – AMA CPT Manual Appendix H

8 □ **Most Commonly Used Modifiers**
   • -21 Prolonged Evaluation and Management
   • -22 Unusual Procedural Service
   • -25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

9 □ **Most Commonly Used Modifier**
   • -26 Professional Component
   • -TC Technical Component
   • -50 Bilateral Procedure
   • -51 Multiple Procedures
   • -52 Reduced Services
   • -54 Surgical Care Only
   • -55 Postoperative Management Only

10 □ **Most Commonly Used Modifier**
    • -56 Preoperative Management Only
11  Global Package Modifiers
   • -24
   • -25, -57
   • -54, -55, -56
   • -58
   • -76, -77
   • -78, -79

12  CPT Surgical Package
   • local infiltration, metacarpal/metatarsal/digital block or topical anesthesia;
   • Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical);
   • Immediate postoperative care, including dictating operative notes, talking with the family and other physicians;
   • Writing orders;
   • Evaluating the patient in the post anesthesia recovery area;
   • Typical postoperative follow-up care.

13  Medicare Global Surgical Package
   • Preoperative visits
     – The day before surgery or the day of surgery
   • Intra-operative Services
     – Normally a usual and necessary part of a surgical procedure
   • Complications Following Surgery
     – All additional medical or surgical services required of the surgeon during post operative period

14  Medicare Global Surgical Package
   • Postoperative Visits
     – Follow up visits during the postoperative period
   • Postsurgical Pain Management
     – By the Surgeon
   • Supplies
• Except for those identified as exclusions; and
  • Misc. Services
    – Dressing changes, local incisional care, removal of operative pack,
      Removal of sutures….

15 □ **Services Not Included Medicare’s in Global Surgical Package**
  • Initial consultation
  • Services of other physicians except where the surgeon and the other
    physician agree on the transfer of care
  • Visits unrelated to the surgical procedure
  • Treatment of underlying conditions

16 □ **Services Not Included Medicare’s in Global Surgical Package**
  • Diagnostic test and procedures
    – Includes diagnostic radiological procedures
  • Distinct Surgical procedures during the postoperative period which
    are not re-operations or treatment complications
  • Treatment for postoperative complications for return to operating
    room

17 □ **Services Not Included Medicare’s in Global Surgical Package**
  • Less extensive procedure which requires more extensive procedure
  • Surgical Tray
  • Immunosuppressive Therapy for Organ Transplants
  • Critical Care Services unrelated to surgery

18 □ **Preoperative Visits**
  • Package includes:
    – Pre-op, Intraoperative, Postoperative Care
  • Subsequent to the decision for surgery
  • One related E&M the day of or prior to the scheduled surgical
    procedure

19 □ **Postoperative Follow Up Care**
• Surgical Days
  –0, 10, or 90 days
  –See Medicare Physician Fee Schedule Database
• http://www.cms.hhs.gov/FeeScheduleGenInfo/

20 □ **E / M Modifiers Only**
• 21 - Prolonged Service
• 24 - Unrelated E/M Service
• 25 - Separately Identifiable E/M
• 27 - Multiple O/P Hospital E/M
• 57 - Decision for Surgery

21 □ **Modifier - 21**
• Prolonged Evaluation and Management Services
  –Prolonged face to face or otherwise greater than that usually required for the highest level of evaluation and management service within a given category
• Not the same as add on CPT codes (99354-99357)

22 □ **Modifier - 22**
• Unusual Procedural Services
  –When the service(s) provided is greater than that usually required for the listed procedure
  –Requires special report
  –Document in detail circumstances that make the case unusual
  –Send documentation in with claim

23 □ **Modifier - 24**
• Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period
• Append to E / M Codes only
• Must know definition of your payor’s global period
  –Claim gets paid—without it claim denied
  Would be denied

24 □ **Modifier - 25**
• Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
• Claims get paid — without it claim denied
• Append to E & M services only

25 Modifier - 26
• Professional Component
  – Fee split between professional component and technical component
  – Use only on global service codes
  – Use when a physician is providing the interpretation of the diagnostic test / study performed
  – Payment of claim is reduced

26 Modifier - TC
• Technical Component
  – Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier -TC to the usual procedure number

27 Modifier - 50
• Bilateral Procedure
  – Only used when the code description does not state “bilateral”
  – Use only when the exact same service is reported for each bilateral anatomical site
  – Know your carrier’s filing requirements for filing bilateral services “single” line item or “double” line item filing requirements
  – Medicare reimbursement rate 150%

28 Modifier - 51
• Multiple Procedures
  – Used to indicate that more than one service was performed by the same physician at the same session
  – Certain CPT codes are modifier -51 exempt
  – Claims get paid at a reduced rate

29 Modifier - 52
• Reduced Services
  – Under certain circumstances a service or procedure is partially reduced or eliminated at the physicians discretion
  – Intended for procedures that accomplished some result, but less than expected for the procedure
  – Claims are paid at a reduced rate
30 □ Modifier - 53
• Discontinued Procedure
  – Under certain circumstances, the physician may elect to terminate a procedure due to extenuating circumstances that may threaten the well being of the patient
  – Procedure was started but was discontinued before completion due to the patient’s condition
  – Claims are paid at a reduced rate

31 □ Modifier - 52 vs. -53

32 □ Modifier - 54
• Surgical Care Only
  – Must be an agreement for the transfer of care between physicians
  – Use box 19 to indicate date of transfer or responsibility
  – Append to surgical codes only
  – Without a transfer of care claims are reported with regular E&M codes

33 □ Modifier - 55
• Postoperative Management Only
  – Must be an agreement for the transfer of care between physicians
  – Use box 19 to indicate date of transfer or responsibility
  – Append to surgical codes only
  – Without a transfer of care claims are reported with regular E&M codes

34 □ Modifier – 56
• Preoperative Management Only
  – Must be an agreement for the transfer of care between physicians
  – Use box 19 to indicate date of transfer or responsibility
  – Append to surgical codes only
  – Without a transfer of care claims are reported with regular E&M codes

35 □ Modifier - 57
• Decision for Surgery
  – An E/M service that resulted in the initial decision to perform surgery
  – Append to E / M codes or Ophthalmological codes in the medicine
• Append to E/M codes or Ophthalmological codes in the medicine section of CPT
  • Claim gets paid – without it claim denied

36 □ Modifier - 79
• Unrelated Procedure or Service by the Same Physician During the Postoperative Period
  – Append to surgical codes to indicate that an unrelated procedure was performed by the same physician during the postoperative period of the original procedure
  – Claims get paid – without it claim denied

37 □ Modifier - 90
• Reference (Outside) Laboratory
  – Use on lab procedures that are performed by a party other than the treating or reporting physician but billed by the physician’s office
  – Not allowed by Medicare
  – Reimbursement stays the same (informational modifier only)

38 □ HCPCS National Modifiers
• E1 - Upper left, eyelid
• E2 - Lower left, eyelid
• E3 - Upper right, eyelid
• E4 - Lower right, eyelid
• RT - Right side
• LT - Left side

39 □ HCPCS Modifiers
• AQ - HPSA
• AR - Physician Scarcity Area
• GA - Waiver of Liability on file
• GB - Claim Resubmitted
• GK - Actual Item / Service Ordered
• GL - Upgraded item, not necessary
• GO - OP Occupational therapy service
• GV - Attending Physician not Hospice
• GW - Service Unrelated to Terminal Condition
• GY - Statutorily excluded
Summary

- The judicious and proper use of modifiers will assist with:
  - Correct billing
  - Communicating the proper information to the payer
  - Not changing the definition of the code, but will show a change in the use of the code

Things To Remember

- Put modifiers that unbundle first (if appropriate) i.e. -59
- Put modifiers that affect payment before informational modifiers to avoid denials
- When the modifier makes the $ go up
  - Increase your fee accordingly before you send your claim in
- Know your payer and know your setting before assigning a modifier

Show Me The Money

- Modifiers should be appended to the CPT code in the proper sequential order to allow for accurate reimbursement
- Always append modifiers that affect payment before informational modifiers
- Must know the carrier’s “Clean Claim” filing requirements

Resources

- Appendix A of the CPT Manual
- HCPCS Manual
- American Optometric Association
  - Eye Care Benefit’s Center; Coding Resources
  - www.AOA.Org

American Optometric Association

Thank You!