Clarifying Selected CPT Modifiers

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Coding for professional services is complicated enough when coding professionals are charged with assisting the physician to select the best five-digit number for the services rendered. It becomes even more complex when circumstances of the case require the CPT code to be modified. Add in the various third-party payer interpretations of modifier assignment and we have a real challenge!

This article discusses a subset of modifiers known to be confusing for physician-based services and explores the differences in use between physician and facility reporting. "Health plan" is used generically in this article and refers to any third-party payer, including government-sponsored programs and managed care plans.

A few years ago, *CPT Assistant* conducted a survey concerning modifiers.[1] Respondents indicated a high level of frustration with CPT modifier reporting for physician claims processing. It was clear at that time many health plans interpret modifier use differently and may not apply them in the manner CPT authors intended. Correct and consistent use of modifiers in the physician office setting can be useful for managing data as well as receiving reimbursement for services. Knowing the variations between CPT guidelines and national HCFA policy concerning modifier usage will help coding professionals understand how physician practice data may be influenced and reimbursement affected.

The 2000 version of CPT contains 30 numeric modifiers that may be used in reporting physician-based services, while only eight are approved for hospital or ambulatory surgery center use. There are numerous HCPCS Level II alphabetic modifiers that are appropriately appended to a CPT code for reporting to Medicare and other government-sponsored payers. Many other health plans also accept them, but we will limit our discussion to the CPT modifiers that create the most controversy and confusion. Few modifiers actually affect the amount of physician service reimbursement, but many modifiers affect claims processing for third-party payment. HCFA allows only those modifiers with national payment policies to affect payment levels.[2]

According to *CPT Assistant*, all modifiers are appended to the five-digit code as a single line item on a claim, or if permitted, on a separate line with a separate five-digit format with the first three digits 099, then the 2-digit modifier. In the past, due to the wording associated with modifier -50 for bilateral procedures, some payers insisted that for reporting bilateral procedures, the CPT code in question be repeated on a second line with modifier -50 appended to the second code. This is not consistent with either HCFA or current CPT directives.[3] Let's discuss several CPT modifiers known to be confusing.

-24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period

This modifier does not affect payment directly, but does help avoid payment denials by indicating that the visit service to which it is attached is not related to a previously performed procedure with a patient still in the postoperative period. Most health plans have a "global fee period" for procedures that includes routine office visits at no extra charge. This encourages patients to follow up with the physician after surgery, because the fee is included in the surgical service. Most physician offices assign CPT code 99024 to this service (Postoperative follow-up visit, included in global service), even though this portion of the care may not be reported to anyone. At least the service is captured within the billing or data management system, because there will be a medical record entry for this service.

Medicare and most other health plans allow reimbursement for other conditions not related to the surgery separate from the global surgery fee. Appending this modifier to the E/M code describes this situation and should prevent claim rejection for the visit service. A diagnosis code other than the condition that caused the patient to have surgery would be expected, although there may be a rare circumstance where the same code would be assigned appropriately, provided medical necessity and the

lack of a relationship to the previous surgery are well documented. (Note: this modifier is only appended to E/M codes and would not apply to facility services.)

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

The use of this modifier becomes challenging when coverage requirements for health plans are encountered, and influence acceptance or denial of the "visit" service when it is reported with a CPT code from the surgery section. CPT guidelines are different from Medicare reporting requirements. CPT recently added clarification within the modifier description that different diagnosis codes are not required when modifying an E/M code. Many health plans may ask for documentation to justify the additional reimbursement if the services link to the same code, because reimbursement for the procedure code usually includes the normal preoperative and postoperative services associated with it. Only a starred (*) procedure in CPT is limited to the surgery portion only, and HCFA and some other payers do not recognize or apply this concept. From their view, it is not that the physician doesn't deserve reimbursement for the evaluation and management services, but that they have included this payment in the payment for the other code.

A good rule of thumb to use in assigning modifier -25 to the E/M service when a procedure also occurs during the visit is to examine the documentation for the key elements for the E/M service. If physician work included separate history, examination, and medical decision making over and above what would be routinely expected with the procedure, assignment of the modified E/M code may be justified.

HCFA guidelines instruct physicians to use this modifier when a separate E/M service is provided on the same date as a "minor" procedure with less than a 10-day global fee period. This includes many of the endoscopic procedures and procedures like cardiac catheterizations. CPT guidelines state that modifier -57 is used to modify E/M services where a decision for surgery takes place to distinguish the visit as separate from the surgical package. It is useful when the decision for surgery occurs on the same day or the day before surgery is performed.

To avoid problems with reimbursement and appropriate reporting of separately identifiable procedures, documentation in the record should support the amount of extra physician work deserving the additional payment. Although it is appropriate from a CPT perspective to report an E/M code to address a problem encountered during a preventive care service, health plans may question reimbursing for two types of service in the same encounter. Documentation must show that the problem-oriented service required performance of the key components over and above those that occurred in the preventive service. Abuse of modifier -25 is likely to result in a focused review to assure that both services actually warrant payment.

Modifier -25 may be introduced for use by hospital-based clinics when the Ambulatory Patient Classification groups are used for Medicare payments this year. The purpose of this modifier for hospital reporting would be to facilitate reimbursement for medical visits that are unrelated to significant procedures or surgical services rendered during the same encounter as the medical visit.

-50 Bilateral Procedure

This modifier is used for both physician and hospital reporting and affects Medicare payment by triggering a payment of 150 percent of the reimbursement rates (RBRVS, ASC, or APC methods). Other health plans may have a similar process. The rationale of the discount is to allow for the fact that the preoperative and particularly postoperative services are not duplicated, so the physician work is really not deserving of twice the rate. Bilateral procedures are only possible on those body parts that come in pairs. Lesion removal using the same CPT code on both arms would not be a bilateral procedure, because the skin is not a paired organ. The unit field on the HCFA 1500 form for a bilateral procedure is always "1" because the modified code represents two procedures. Although some health plans may require the code to be listed twice with the second code modified, both HCFA and the AMA (through CPT guidelines) direct bilateral procedures to appear with one modified CPT code per line. Only those CPT procedures where the terminology does not identify the procedure as bilateral should be modified. If the procedure is identified by the description as "unilateral or bilateral," the code should not be modified.

Medicare has a numeric indicator of 0, 1, 2, or 3 in the Medicare Fee Schedule Database (Field 22) associated with selected CPT codes for services to assist with understanding payment impact of modifier -50.[4]

0 The bilateral payment adjustment is inappropriate for these codes due to physiology, anatomy, or because the code description specifically states that it is a unilateral procedure and there is a specific code for the bilateral procedure.
1 The bilateral payment adjustment for these codes is appropriate because the code description is for a unilateral service and physiology permits the service to be performed bilaterally.
2 The Medicare fee schedule amount for these codes was established as a bilateral service, because the code description specifically states that the procedure is bilateral.
3 The usual payment adjustment for these codes does not apply. Services in this category are generally radiology procedures or other diagnostic tests. Payment is based on the lower of the actual charge for both sides or 100 percent of the fee schedule for each procedure if the code is reported with modifier -50 or is reported for both sides on the same day by any other means.

-51 Multiple Procedures

This modifier is used only by physicians to indicate additional procedures (performed along with a primary procedure) by the same physician at the same operative session. It is never used with an "add-on" code listed in Appendix E of the CPT manual. Appendix F lists those codes that are exempt from modifier -51 requirements and are not considered "add-on" codes. This modifier often affects reimbursement, because most health plans have a reduction for subsequent procedures performed at the same time. Medicare allows 100 percent for the first procedure and then reduces the subsequent procedures to 50 percent. A special discounting formula is applied to endoscopic procedures and Medicare reporting guidelines prohibit attaching modifier -51 to subsequent procedures in the same endoscopy "family." If multiple endoscopic procedures are in a different endoscopic family (i.e., performed via a different scope), then modifier -51 is applied to the additional procedures following the first listed endoscopy. Care must be taken to correctly code endoscopic procedures without unbundling components of a comprehensive procedure in this process.

Physicians should protect reimbursement levels by assigning full charge amounts for each procedure to health plan claims and allowing the plan to apply the appropriate discounting. For self-pay patients or those with plans that reimburse a percentage of charges, a designated standard discount may be applied, so they may be treated the same as other patients for surgical services.

Most of the problems surrounding modifier -51 occur because of confusion about when to use it or modifier -59 for distinct procedural services. Modifier -59 is used for multiple procedures, but is limited to those that represent a service that is distinct from another procedure and reflect a separate session, different site or organ system, or is a distinct lesion or injury that is not apparent by the reporting of CPT codes alone. In most circumstances, modifier -59 explains reporting of a "separate procedure" or an "unbundled" code that would normally not be reported as a separate code, yet is appropriate in the circumstances.

-52 Reduced Services

This modifier is used by both physicians and hospitals, but for slightly different reasons. For physicians, -52 is used to reflect a reduction in the service described by the CPT code without disturbing the identification of the basic service. CPT guidelines direct the use of modifier -52 for an incomplete colonoscopy with full preparation for a colonoscopy. This creates some confusion, because Medicare policy directs physicians to report modifier -53 for an "incomplete" colonoscopy with the example given to define an incomplete exam as "the inability to extend beyond the splenic flexure."[5] Many coders would assign the code for sigmoidoscopy in this case. The RBRVS value (Non-facility Transitional Value for 2000) for the modified code 45378-53 is slightly lower in the Medicare Fee Schedule for 2000 than code 45330 (sigmoidoscopy). This is an area where more clarification is needed to assure consistent application of modifiers when less than the code description is provided in the service.

Although some physician practices would like to use modifier -52 on an E/M code to show that less service was rendered than the code description, this is not a CPT guideline-directed practice, nor will most health plans accept this use of modifier -52. To some coders, it is also tempting to use this for preventive care that is less than comprehensive, such as a school or sports physical.[6] Some practices would also like to append it to visit services that are missing some or all of the key components. Before using modifier -52 on an E/M code, contact the health plan involved to assess the effect on reimbursement for the

service. It is almost always necessary to furnish documentation to explain to the payer what services were provided, so appropriate payment is made based on coverage requirements.

For hospital reporting, it appears that use of modifier -52 is primarily for radiology procedures, now that specific modifiers are available for reporting terminated procedures. According to the latest transmittal, use of modifier -52 does not currently result in a reduction in payment for the procedure.[7] For physician reporting, the payment impact of modifier -52 is subject to carrier-specific processes.

-53 Discontinued Procedure

For physician reporting, this modifier is used when "extenuating circumstances that threaten the well-being of the patient" cause the physician to terminate a planned procedure. It is used for reporting a service that did not make it to the operating suite or were canceled for a reason other than the physician's decision to terminate before completion. This modifier is no longer approved for hospital reporting, because modifiers -73 and -74 were introduced for facility reporting. Although there is no specific CPT directive included in the manual, it is generally accepted that this modifier may be used for those procedures that were planned, yet not carried out by physicians. Health plans may differ on how this modification affects reimbursement for the physician's services. For Medicare reporting, only the code for diagnostic colonoscopy has a specified relative value associated with the modified code, and no other endoscopy codes have one. Unless the physician work is significantly less than the planned procedure, it would be expected that the fee associated with these modified procedures would be the same as an unmodified procedure.

For data management purposes, modified codes can be easily distinguished from those procedures that were completed as expected.

Summary

This discussion includes only 20 percent of the modifiers available for physician reporting, but could account for 80 percent of modifiers assigned for physician services. Modifier -91 was the only new modifier introduced in CPT 2000 and it is used to report a repeat clinical diagnostic laboratory test. It is not to be used when confirming initial results or for any other reason other than a clinical need to repeat the test for the same patient on the same day. Success with CPT modifier reporting requires a thorough review of CPT guidelines and some detective work for identifying health plan requirements for modified codes.

Notes

1. American Medical Association. "Readers Respond to Faxback Survey on Modifiers." *CPT Assistant* 7, no. 9. Chicago, IL: American Medical Association, 1997.
2. Soc. Sec. Act. ß1848 (c) (4).
3. American Medical Association. "Use of the Bilateral Modifier." *CPT Assistant* 2, no. 1. Chicago, IL: American Medical Association, 1992.
4. Medicare Carriers Manual, § 15040 as revised by Transmittal 1546 (June 1996).
5. Medicare Carriers Manual, Part 3 (HCFA Pub. 14-3).
6. American Medical Association. "A Review of Preventive Medicine Services." *CPT Assistant* 7, no. 8. Chicago, IL: American Medical Association, 1997.
7. Medicaid and Medicare 1999 Program Memos, Transmittal No. A-99-41, *Clarification of Modifier Usage in Reporting Outpatient Hospital Services*, September 1999. Available at www.hcfa.gov/pubforms/transmit/A994160.htm.

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