Physician Office Modifiers Provide Added Detail for Coders

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In elementary school, we were taught that adjectives and adverbs amplify stories, providing extra detail. Take for example the following sentence: "The girl ran." What does it really tell us about the girl? If we add some adjectives, an adverb, and even a prepositional phrase, we get a clearer picture about what is going on. "The frightened little girl ran recklessly home in the dark."

Physician office modifiers are like adverbs and adjectives and tell, as commentator Paul Harvey likes to say, "the rest of the story." Coders often need modifiers to communicate the full extent of a procedure in order for their organizations to get paid appropriately and to eliminate conflicts over claims denials. This article reviews some commonly used modifiers in physician practices.

Modifier 25

Modifier 25 is commonly used to communicate in detail the service provided to a patient on a given visit. It indicates that a patient evaluation went above and beyond what would normally be required for a procedure.

For example, a child presents with a 3-cm laceration on his leg. The doctor treats the laceration with a single layer repair. The appropriate codes for the procedure would be 891.0, Open wound of knee, leg [except thigh], and ankle, and CPT code 12002, Simple repair of superficial wound of scalp, neck, axillae, external genitalia, trunk and/or extremities [including hands and feet]; 2.6 cm to 7.5 cm. No separate evaluation and management code is reported because the evaluation of the wound is included in the laceration repair procedure.

If, however, the child also suffered a chronic condition that could affect his ability to heal, or if the laceration resulted from a fall in which the child also suffered other significant injuries, the physician would be required to perform a more extensive evaluation, which would be reported separately with modifier 25.

Case Example

Timmy, age 9, presents with a 3-cm laceration on the lower part of his left leg. He is a known type 1 diabetic. The physician evaluates the diabetes and performs a single layer repair.

The codes assigned are 891.0, 250.01, 12002, and 99212-25. (Note: the evaluation and management code 99212 is used here as an example. The evaluation and management level would have to be supported by documentation of the history, exam, and medical decision making for the diabetes in this case.)

Modifier 25 is always attached to the evaluation and management code. In this case, it would be inappropriate to attach modifier 25 to the laceration repair code. The physician's documentation is an extremely important factor here. The physician must clearly document the factors that affect patient care and anything that will impair the patient's recovery.

According to the 2005 Office of Inspector General work plan, modifier 25 is often used incorrectly in physician office coding.[1] The guidelines for the appropriate use of modifier 25 are clearly explained in the CPT book. Physician office coders should understand these modifiers completely before applying them.

Anatomic Modifiers

Anatomic modifiers are descriptors that were created in recent years. Specialists such as orthopedic physicians and podiatrists frequently use anatomic modifiers because they often treat or repair the same conditions of multiple fingers or toes. These

modifiers tell payers that the physician performed a procedure multiple times on various appendages. They are intentionally and appropriately reported for the same procedure more than once.

Formerly, only LT and RT modifiers were available, and physicians found themselves frequently fighting denials for what appeared to be duplicate services. Now a physician reporting drainage of a finger abscess on more than one finger on the same hand can apply the applicable modifiers from FA through F9 to explicitly communicate on which finger the procedure was performed.

Modifers LT and RT are still useful and are applied to codes that identify procedures performed on a contralateral anatomic site (e.g., joints, bones) or on paired organs (e.g., ears, eyes, kidneys, ovaries). LT and RT help identify the side on which a procedure is performed and are especially important when procedures are performed on both sides.

Case Example

A physician performs an excision of a lesion on the right breast and a needle biopsy of a suspicious lump on the left breast. The CPT codes assigned are 19120-RT and 19100-LT.

Use of these modifiers clarifies that a lesion on the right breast was excised, while a lesion on the left breast was biopsied. This distinction is important because if the biopsy and excision are related to the same lesion, both codes would not be reported.

Modifier 59 is used to denote that a distinct procedure was performed. It communicates that a procedure was performed at a different site, through a separate incision, or that a separate lesion was addressed. So in the case example above, if the procedures involved separate lesions on the same breast, CPT codes 19120 and 19100-59 would be reported.[2]

Modifiers GA, GY, and GZ

Three other modifiers that plague the unwary physician office coder are GA, GY, and GZ. These modifiers are used to communicate information about Medicare's advance beneficiary notice (ABN), a written notice given to a Medicare beneficiary. The ABN informs a beneficiary, before he or she receives specific services, that Medicare probably will not pay for the service.[3] The patient is asked to sign the ABN form and thus accept financial responsibility for the service. An ABN must be signed every time the doctor orders a procedure that Medicare will likely not pay. The GA modifier is appended to the claim when the practice has a properly signed and executed ABN on file.

The GY modifier clarifies that the service provided is something that Medicare has statutorily excluded and will never pay for, such as ordering a patient to use a tanning bed, acupuncture, or alternative medical treatments that may be effective but are disallowed by Medicare. Medicare does not take a stand on the efficacy of the treatments; it merely has not determined them to be as effective as or more effective than traditional medicine.

The GZ modifier covers those situations when a test or treatment is not felt to be medically necessary or reasonable. This may occur in cases where Medicare has set a frequency guideline on how often it will cover a given test, such as a PSA test. A physician may feel that due to a patient's history or other risk factors, a test needs to be repeated more often than Medicare guidelines allow. In this case, the physician and staff must educate the patient on why the test is needed and allow the patient to make an informed choice to proceed with the test and bear the cost.[4]

The More You Know...

Modifiers are defined in detail in appendix A of the CPT code book. CPT guidelines imbedded within the CPT code book further explain appropriate use of modifiers applicable to a specific range of codes. For example, the surgery guidelines located just prior to code 10021 explain the use of modifiers applicable to CPT surgical codes. Symbols used throughout CPT also provide guidance on appropriate modifier use. For example, ? is used to identify codes that are exempt from the use of modifier 51 but have not been designated as CPT add-on procedures or services.

Consequences for misuse of modifiers are similar to those for other types of coding errors. Payers may ask for recoupment or recoupment plus interest. If there is indication of intent to commit fraud, criminal penalties may apply.[5]

Physician office coders who either do not use modifiers or use them incorrectly cost their practice dollars in decreased efficiency, increased denials, and increased audit risk when patterns of incorrect or inappropriate coding are detected. It is incumbent on the coding professional to use modifiers appropriately to communicate "the rest of the story."

Notes

1. Office of Inspector General. "HHS/OIG Fiscal Year 2005 Work Plan—Centers for Medicare and Medicaid Services." Available online at http://oig.hhs.gov/reading/workplan/2005/2005WPCMS.pdf.
2. Centers for Medicare and Medicaid Services. "Modifier -59 Article." Available online at www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf.
3. For more information on Medicare ABNs, read the brochure provided for physicians available on the CMS Medlearn Web site at www.cms.hhs.gov/MLNProducts/Downloads/ABN_READERS.pdf.
4. Information about ABNs may also be found in chapter 30 of the Medicare Claims Processing Manual (Medicare Internet-Only Manuals, publication #100-4) available online at www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage.
5. For information on fraud and abuse, visit the Office of the Inspector General Web site at http://oig.hhs.gov/index.html.

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