

Demystifying Modifiers

Prevent delays in reimbursement by using -25 and -59 properly.

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The accurate use of Current Procedural Terminology (CPT) modifiers is important for securing reimbursement for glaucoma treatment. When used correctly, modifiers can (1) prevent denied or rejected claims by communicating the service more clearly and (2) increase reimbursement.

The use of modifiers is not without problems, however. Their improper application reduces the billing office's productivity by increasing time spent following up on denied claims. Equally as important, the inappropriate use of modifiers can result in paybacks to third-party payers.

MEASURING MISUSE

In 2005, the Office of Inspector General (OIG) released two reports^{1,2} identifying several problems surrounding the use of the modifiers -25 (distinct procedure) and -59 (significant, separately identifiable evaluation and management [E/M] service by the same physician on the same day of the procedure or other service).

These reports found that 35% of the claims allowed by Medicare in 2002 using modifier -25 did not meet program requirements, which resulted in \$538 million in improper payments. Forty percent of code pairs billed with modifier -59 in fiscal year 2003 did not meet program requirements. Misuse of this modifier resulted in \$59 million in improper payments. The OIG has therefore encouraged Centers for Medicare & Medicaid Services carriers to conduct pre- and postpayment reviews on claims with these modifiers.

If you do not do so already, be sure to include some claims with the -59 and -25 modifiers in your internal compliance audits. Key words in the description of these modifiers are critical to the proper use of these important coding tools.

USING THE -25 MODIFIER

When

The CPT Manual established the -25 modifier to designate "a significantly, separately identifiable service by the

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same physician on the same day of a procedure or other service." It is usually associated with minor surgical procedures that include zero to 10 postoperative days in the global care period. The -25 modifier only applies when E/M services are beyond a procedure's assigned pre- and postoperative care.

Every procedure eligible for Medicare payment has some aspect of E/M service such as reviewing the procedure, confirming informed consent, and assessing problematic areas. If you want to use the -25 modifier to bill an E/M service in conjunction with a minor procedure, you must include the CPT code for the minor procedure, the E/M service with the -25 modifier attached, and the appropriate ICD-9 code. Medical records must include an appropriate history as well as documentation showing that the examination and medical decision-making were significantly over and above the E/M service associated with the billed procedure.

Example

Consider a glaucoma patient who uses IOP-lowering drugs but still has uncontrolled pressure in both eyes. After taking a history, performing an examination, and documenting your medical decision-making, you conclude the patient should undergo argon laser trabeculoplasty (ALT) in his right eye on that same day. The service is billed using the appropriate level of service for the visit and the appropriate code for the ALT-RT. Attaching the -25 modifier indicates you performed a

TABLE 1. NATIONAL CORRECT CODING INITIATIVE PROCEDURAL CODE MODIFIER INDICATORS

Modifier Indicator	Definition
0	No modifier may be used to bypass the edited pair of codes.
1	A CPT modifier may be used to differentiate between services provided at the same session on the same site.
9	The code pair has been deleted from the NCCI system.

separate, identifiable E/M service in conjunction with the procedure.

What if, instead, the patient returns for ALT 2 days after the initial examination? If that procedure is the only reason for the visit, and no significant, separately identifiable E/M services are performed at that time, the appropriate code is ALT-RT.

Remember, the -25 modifier is always attached to the E/M service and is not needed if that service is the only one performed that day.

Potential Pitfalls

Medicare does not require two separate ICD-9 codes when using the -25 modifier. Other carriers may, so be sure you are familiar with your carrier's rules.

USING THE -59 MODIFIER

When

The National Correct Coding Initiative's revisions identify when two procedural codes may not be reported together. Codes from column one of the CPT/Healthcare Common Procedure Coding System are comprehensive, and those from column two are component. It is considered "unbundling" when a physician adds a code from column two to one from column one because the former is considered "part" of the latter.

If a pair's assigned modifier indicator allows, two procedural codes may be billed together using the -59 modifier (Table 1).

The -59 modifier indicates that services usually are not performed together but that the combination may be appropriate under certain circumstances. Qualifying criteria include:

- different sessions;
- different procedures or surgeries;
- different anatomic sites or organ systems;
- separate incisions or excisions;
- separate lesions; and
- separate injuries.

Documentation in medical records must indicate that one service was separate and distinct from other services

performed during the same session or patient encounter.

Potential Pitfalls

Modifier -59 is often used incorrectly. Its primary purpose is to indicate that two or more procedures were performed at different sites or sessions. It should only be used when no other modifier defines the situation appropriately.

To facilitate timely processing, physicians should attach the -59 modifier to the column two code. The OIG study² identified a number of applications in which the -59 modifier was attached to the primary code versus the column-two code as well as instances when the modifier was attached to primary and secondary codes.

I frequently see practices confuse modifier -59 with modifier -51. The latter tells the carrier that the physician performed more than one surgical procedure during the same session. Modifier -59 tells the carrier that the physician "unbundled" procedures that cannot normally be paid together because of the special circumstances described in the submitted bill. The failure to distinguish between these codes when billing carriers can affect reimbursement.

CONCLUSION

Modifiers play a critical role in submitting clean claims and obtaining accurate reimbursement. It is incumbent on you and your staff to understand when and how to use these coding tools when billing for services. □

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1. Use of modifier 25. Available at: <http://www.oig.hhs.gov/oei/reports/oei-07-03-00470.pdf>. Accessed May 3, 2006.

2. Use of modifier 59 to bypass Medicare's national correct coding initiative edits. Available at: [oig.hhs.gov/oei/reports/oei-03-02-00771.pdf](http://www.oig.hhs.gov/oei/reports/oei-03-02-00771.pdf). Accessed May 2, 2006.