Dermatology Coding Alert

Modifiers: Make Your CPT® Code Fit the Procedure With the Right Modifier

Some modifiers may look alike, but each has its own distinct purpose and the difference can mean success or failure for your claims.

Even if you're brand-new to dermatology coding and billing, you likely are familiar with at least a few modifiers. But for an overworked coder, what is seemingly simple can become complex, especially when you have to choose between a few modifiers that seem quite similar.

Read on for some expert advice on minimizing modifier mayhem, and maximizing your deserved reimbursement.

There are several modifiers commonly used in dermatology practices, says **Ryan Price, CPC,** AHIMA-Certified Instructor, who presented a Modifiers seminar at the recent CodingCon conference:

- 22 Increased procedural service
- 24 Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period
- 25 Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the day of a procedure or other service
- 26 Professional component
- 50 Bilateral procedure
- 51 Multiple procedures
- 52 Reduced service
- 53 Discontinued procedure
- 57 Decision for surgery
- 58 Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period
- 59 Distinct procedural service
- 76 Repeat procedure or service by the same physician or other qualified health care professional
- 78 Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period
- 79 Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period
- RT Right side
- LT Left side.

In addition, there is a series of "X modifiers" (XE, XS, XP, and XU) which were introduced to replace modifier 59. More on those below.

Know the Payment Vs. Pricing Difference

To understand how a modifier attached to a CPT® code affects your claims, you need to know the "payment vs. pricing" distinction, Price says. The two things to consider are:

- **Payment:** If a modifier is not added, will it affect getting paid?
- **Pricing:** If a modifier is not added, will it affect the value of the code?

Payment modifiers: If you neglect to append these modifiers when they're justified, Price says, it may affect whether or not the insurer reimburses for the service. Payment modifiers include:

- 24
- 25
- 57
- RT, LT.

Pricing modifiers: If you neglect to add one of these modifiers when it's called for, Price says, it may affect the value of the code i.e., how much you will be reimbursed for it. Pricing modifiers include:

- 22: This modifier "may increase the fee anywhere from 18 to 25 percent," notes Price.
- 50: This modifier has the potential to increase your fee 50 percent, if the Medicare Fee Schedule allows for bilateral reporting.
- 51: This modifier "reduces the fee typically 50 percent," says Price.
- 52: Depending on the payer, this may reduce the fee up to 50 percent, says Price.
- 53: This modifier may also reduce the fee up to 50 percent, depending on the payer.
- 59: "Payers typically consider this the same as modifier 51, and reduce the fee 50 percent," Price says. The same is true for the X modifiers, he says.
- 78: The payment for the procedure is typically reduced by the value of the postoperative period.

Lean on X(EPSU) Instead of 59 When Appropriate

The Centers for Medicare and Medicaid Services (CMS) has described modifier 59 as "the most widely used HCPCS modifier," which certainly holds true for most practices, which use it routinely to split codes that have been bundled together by the Correct Coding Initiative (CCI). But CMS notes that many providers misuse it for that purpose. "The 59 modifier often overrides the edit in the exact circumstances for which CMS created it in the first place," CMS has said.

To address the problem, CMS created "more precise coding options" with the X(EPSU) modifiers, introduced in January 2015:

- XE Separate encounter
- XS Separate structure
- XP Separate practitioner
- XU Unusual non-overlapping service.

"CMS will not stop recognizing the 59 modifier but notes that CPT® instructions state that the 59 modifier should not be used when a more descriptive modifier is available," says a CMS transmittal released in 2014. "CMS will continue to recognize the 59 modifier in many instances but may selectively require a more specific X(EPSU) modifier for billing certain codes at high risk for incorrect billing."

And as for 59 and X(EPSU) themselves, "only use these modifiers if there aren't more specific modifiers available," Price advises.

Keep Your Modifiers in Order

When multiple modifiers apply to a procedure, which should you list first?

If you are reporting a code that is bundled into another procedure by the National Correct Coding Initiative (NCCI), you should first list any modifiers that justify reporting the two procedures together modifiers like 59 that show that the

procedure was necessary and distinct from the other service, say experts.

Next: List any modifiers that affect payment, such as 50 or 51.

Then: List any "informational" modifiers such as RT or LT that will not affect the reimbursement for the CPT® code but provide more specific information such as what side the dermatologist performed the procedure on.

Listing informational modifiers before payment modifiers may lead to denials, experts say.