Part B Insider (Multispecialty) Coding Alert

Modifiers: Avoid These 5 Major Modifier Errors to Keep Your Cash Flowing

Reporting modifier 78 for a staged procedure? Expect denials.

When it comes to appending CPT® modifiers to your codes, the rules can be daunting, and Medicare's regulations only compound the confusion. But if you're up to speed on these key modifier billing practices, you'll be raking in deserved pay. Check out the following five tips to ensure that you aren't missing any opportunities

1. Don't Avoid Modifier 26.

If your physician provides an interpretation and report for an x-ray or other radiological service in the treatment of a patient, that's not always just part of his E/M--in some cases, you can separately bill for the interpretation and report by appending modifier 26 (Professional component) to the CPT® code.

Typically, the technologist that performed the patient's x-ray will bill the code -- such as 71010 (Radiologic examination, chest; single view, frontal) -- with modifier TC (Technical component) to indicate that he is billing for the equipment, room charge, film and radiologic technician, but not for the physician's interpretation. If the physician who renders the interpretation is with a separateprofessional group and is not a hospital employee, you should report the service with modifier 26 to obtain his proper share of the reimbursement.

2. Know the Difference Between Modifiers 58 and 78.

Because both modifier 58 and 78 describe procedures performed during another surgery's global period, it can be easy to confuse them. But differentiating between the two can mean the difference between collecting your due and filing endless appeals.

Key: You'll report modifier 78 (Unplanned return to the operating room for a related procedure during the postoperative period) when conditions arising from the initial surgery (complications) rather than the patient's condition -- call for a related procedure.

Staged procedures: You should append modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) when a procedure or service is planned or anticipated at the time of the original procedure (staged), is more extensive than the original procedure, or represents therapy following a surgical procedure. You need not return the patient to the operating room to report modifier 58. You must, however, return the patient to the OR to qualify for modifier 78.

Example 1: Suppose the physician places a gastrostomy tube (49440), but eight days later, the tube leaks and the doctor returns the patient to the OR to change the tube. In this case, you should append modifier 78 to the second procedure, because the initial procedure (49440) has a 10-day global and the leak wasn't planned, so for the physician to get paid for this service, the modifier would be required.

Example 2: The surgeon excises an ischial pressure ulcer with ostectomy. Several days later, she closes the operative wound using a muscle flap. For the initial procedure (the excision), you should report 15946 (Excision, ischial pressure ulcer, with ostectomy, in preparation for muscle or myocutaneous flap or skin graft closure). You would claim the muscle flap closure at a separate session with 15734 (Muscle, myocutaneous, or fasciocutaneous flap; trunk). Append modifier 58 to 15734 to show the payer that the closure during the global period was anticipated at the time of the initial procedure.

How can you tell? When determining whether a procedure was "staged," check the physician's notes, because he'll often indicate that another procedure is planned. In the final summary of the procedure, the physician might say, "the patient is to return to the office in six number of days for the following additional procedure..."

Part B reminder: Medicare payers consider all postoperative complications "related" to the initial surgery unless the patient must be returned to the operating room. For instance, suppose a patient develops a minor infection at the surgical wound site. The surgeon simply cleans and dresses the wound in his office. In this case, the original procedure's global surgical package includes the uncomplicated follow-up care.

3. Mine All Legitimate Modifier 59 Opportunities.

Some coders assume that if the Correct Coding Initiative (CCI) forbids billing two codes on the same date, that's the end of the story. But in fact, you may be missing out on some legitimate cases where CCI allows you to use a modifier such as 59 (Distinct procedural service) to override an edit. Always scan the CCI edits to see whether a modifier can override your code pair edit. Of course, you should only use the 59 modifier when the servicesare separate, distinct, and medically necessary.

4. Keep Modifier 50 in Mind.

Many procedures are inherently unilateral, and you won't receive full reimbursement for bilateral versions of those procedures unless you append modifier 50 (Bilateral procedure).

Watch out: Coders often forget the 50 modifier for bilateral spinal injection and diagnostic ophthalmology procedures, but many of these services do allow bilateral billing if the documentation demonstrates that the physician performed a bilateral service. You can determine which procedures allow it by reviewing the Medicare Physician Fee Schedule's column "Z" (which is marked "BILAT SURG.")

5. Appeal When You Feel You've Been Wronged.

Because many practices fear being labeled "troublemakers" or even worse yet, non-compliant with the False Claims Act's regulations, they accept Medicare payers at their word when a modifier isn't accepted or the claim is denied.

If your MAC denies your claim or requests a refund, research the issue before you take the payer's word for it. Most experts caution against rolling over with regard to alleged overpayments. If it is a clear overpayment, you must give the money back. However, if the claims were properly submitted and billed, you should appeal any time you feel your payer has wrongly denied your claim or incorrectly requested a refund.