Part B Insider (Multispecialty) Coding Alert

Modifiers: Boost Modifier Know-How With 12 Handy Tips

Warning: Watch out for modifier 95 slip-ups.

Despite the fact that Medicare providers use modifiers on their claims every day, there exists a lot of confusion on these codes' rules, leading to long-term issues and denials. To perfect your modifier game, it's smart business to review other providers' modifier mishaps to circumvent problems in your own practice.

That was the word from the webinar "Avoiding Modifier Rejections" presented by Medicare Part B payer CGS Administrators on October 21, 2020. During the session, CGS' **Juan Lumpkin** outlined the most important facts to know about commonly used modifiers, and shared information on the most frequent problems he sees when reporting them. Check out a few of his insights below.

Tip 1: Modifiers Are Supplements

"The use of modifiers is an important part of coding and billing for healthcare services," Lumpkin said. "Modifiers are two-character codes reported with CPT® and HCPCS [Level II] codes to modify or supplement the description of services rendered based on certain exceptions or circumstances. They do not change the code description, but they simply supplement the description of those codes."

"Using them correctly will help make it clear why certain codes that are normally or shouldn't be billed together are billed together, which helps avoid questions of fraud or abuse from the provider's perspective," he explained.

Tip 2: Modifiers Frequently Prompt Denials

If you think modifiers aren't important enough to cause denials among your claims, think again. "The category 'invalid or incorrect procedure code/modifier combination' is always among the top 10 claims submission errors," Lumpkin noted.

Tip 3: Not All Modifiers Are Created Equal

There are different types of modifiers available, he said. Some are considered payment modifiers, which have a direct impact on how much you'll collect for the service. For instance, modifier 52 (Reduced services) tells the payer that a service should be reduced, and the documentation you send with it explains how the payer should manually cut the reimbursement for the service.

Other modifiers are considered informational, showing whether they may meet exceptions that allow you to bypass certain edits. Modifier 59 (Distinct procedural service) is an example of this, he noted.

Tip 4: Not Every Payer Accepts Every Modifier

"Just because the AMA creates a modifier or even defines a modifier, does not mean that that modifier applies to Medicare claims," Lumpkin said. "Those are not just for Medicare claims; other payers use them as well, and CMS dictates whether a particular modifier will apply to Medicare claims."

To determine whether a modifier applies to your service, refer to the Medicare Physician Fee Schedule (MPFS), which shows whether particular modifiers such as 50 (Bilateral procedure), 62 (Two surgeons), or 66 (Surgical team) might apply to a particular code.

"If you're ever questioning whether a modifier applies to your situation, I would encourage you to look at the database tool," he said. Each payer will maintain their own database look-up tools, and you can also refer to the MPFS on the CMS website as well, he noted.

Tip 5: Modifier 95 Caused Many Recent Denials

Data from CGS indicates that modifier 95 (Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system) was by far the modifier responsible for the highest number of rejections within the past few months, Lumpkin said.

Other commonly rejected modifiers include 59, GT (Via interactive audio and video telecommunication systems), 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service), 26 (Professional component), 51 (Multiple procedures), 50 (Bilateral Procedure), RT (Right side), and LT (Left side).

"CPT® modifier 95 is for telehealth services," he acknowledged. "I'm sure all of you can agree that there was a lot of confusion early on with telehealth modifiers once the public health emergency (PHE) was announced."

Although modifier 95 was fairly straightforward prior to the COVID pandemic, it's become more confusing since the PHE began and the rules were adjusted, he said. "If you're performing services allowed via telehealth that would normally have been performed face to face but now you're performing them via telehealth with dates of service on or after March 1, 2020 and for the duration of the PHE, bill with the place of service equal to what it would have been had the service been furnished in person, and with modifier 95, indicating that the service rendered was actually performed via telehealth," he said.

Most MACs have performed mass adjustments of those claim submissions to account for the confusion that existed early on in the pandemic, he noted.

Tip 6: Modifier 59 Denotes an Exception to Bundling Edits

When it comes to modifier 59, which is also rejected frequently due to errors, "this is the modifier that's used mostly to let us know that there are two services done on the same date, typically which cannot be billed on the same date of service, however, this service meets the exception," he said. "To find out whether or not certain codes can be billed separately, CMS has a great file on its website, the procedure-to-procedure code pairs," he advised. If you download this sheet, you'll see the different code pairs and determine whether they can be billed together on the same date of service with the modifier appended. No matter what, your documentation must support the fact that you're requesting an exception to the edit.

However, modifier 59 won't be the only modifier that may apply to your claim when you're trying to separate edits, he said. "Use modifier 59 when no other modifier would accurately describe the exception," he advised.

Tip 7: Modifier GT Is No Replacement for Modifier 95

HCPCS Level II modifier GT is one of the original telehealth modifiers and refers to telehealth services specific to critical access hospitals (CAHs). "This is for a telehealth service billed under a CAH Method II, for facility-type billing," he said. "The data suggest that this modifier was billed to Part B because providers weren't sure which modifiers to bill early on during the PHE. But this should be used for institutional, or Part A claims," he mentioned.

Tip 8: Most Procedures Include Evaluation Component

Modifier 25 is also ranked as one of the most commonly rejected modifiers, Lumpkin noted.

"Basically what this modifier does is it pays for E/M services any time a minor procedure is done on the same date.

Typically, when a patient comes in for a minor procedure, the only thing you're to bill Medicare for is that minor procedure. The fee schedule amount that CMS assigns to minor procedures includes an evaluation component to it already. So under normal circumstances, an additional E/M service is not allowed," he said.

However, if your documentation demonstrates that you performed a distinct, separately identifiable E/M service along with the procedure, you can append modifier 25 to your E/M code.

Tip 9: Not All Services Allow Modifier 26

Modifier 26 should be used to report the professional component only of a global service. "This is used on diagnostic services, such as radiology," he said. "The professional component is the reading of the results of that test, and the technical component is the performance for that test. If the provider is just billing for the professional component of the test, they can use modifier 26. Before you use that, make sure you refer to the definition of the code," he said. The fee schedule can show you which codes allow you to report the professional and technical components of a particular code. For example, you would not report the interpretation of 93000 (Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report) with modifier 26 for your interpretation of that EKG tracing, because a separate code, 93010 (... interpretation and report only), exists to describe the specific professional component for that scenario.

Tip 10: Payers Will Add Modifier 51, So You Don't Have to

Modifier 51 is another code that is rejected fairly frequently, cautioned Lumpkin. "This is a system-generated modifier used to help payers appropriately price multiple surgical procedures performed on the same date of service," he said. "If you bill multiple surgical procedures on the same date of service, our system has to determine how to price all of those procedures, so it ranks them by the fee schedule amount, so the service allowed at the highest amount is allowed at 100 percent, but the second through fifth procedures performed on the same date are reduced down to 50 percent. If the services that you bill apply to multiple procedure pricing, our system will add that modifier, so please do not add this modifier because it could cause reimbursement problems for your procedures. The system handles how to rank or price these multiple procedures. If you add it to a procedure, our system may reduce that by an additional 50 percent, so that will cause some problems for you when it comes to reimbursement." While this may be true for some payers, it is not a universal process, so your best bet is to check with your individual payers.

Tip 11: Check Descriptors Before Using RT, LT, and 50

Also on the list of frequently rejected modifiers are RT, LT, and 50, he said. "RT and LT are location modifiers, used to identify where a procedure was performed. The database on the CMS website will tell you whether a specific code allows for bilateral billing, whether it's RT/ LT or modifier 50. They do the same thing, so look at the definitions of the indicators to tell you specifically whether you can use these."

Tip 12: Only Use Modifier 57 With 90-Day Globals

Modifier 57 is used "only when the decision for surgery was made during the pre-op period of a major surgery (services with a 90-day follow-up period)," he said. "The preoperative period is the day before and the day of the surgical procedure."

For instance, if you perform fracture care at your practice, you will append modifier 57 to the E/M code, allowing you to also collect for the fracture care. While correct coding requires you to apply modifier 57 to a major procedure, some payers still request modifier 25 instead, so always check with your insurers on their requirements.