Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Modifiers: Determine Your Modifier Skill Level With This Quiz

Once you have your modifiers straight, you'll be coding with ease.

It's been said that appropriate use of modifiers can make or break your Medicare claim, so if your modifier knowledge hasn't been updated in a few years, you could be losing reimbursement.

Check out the following five questions and answers to determine whether your modifier utilization rates an A+.

Question 1: You performed a lipid panel on a 40-year-old male patient as a screening. Which modifier should you report along with 80061 (Lipid panel)?

A. Modifier 50
B. Modifier 25
C. Modifier 33
D. Modifier 59

Answer: C. The full definition of modifier 33 (Preventive services) reads as follows: "When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used."

Modifier 33 isn't appropriate for every preventive service. Only report it for services that (1) are not inherently preventive and (2) were provided as preventive in the particular situation.

In the question above, your practice performed a lipid panel on a 40-year-old male patient as a screening. "Cholesterol abnormalities screening: men 35 and older" carries a US Preventive Services Task Force rating of A (www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm). If the payer requires modifier 33, append the modifier to 80061 (Lipid panel). An appropriate diagnosis code (such as V77.91, Screening for lipoid disorders) also can help identify the service as preventive rather than diagnostic or therapeutic.

Modifier 33 was created in response to the Patient Protection and Affordable Care Act, which requires most health plans to cover certain preventive services without patient cost sharing. The modifier helps physicians indicate such services on their claims.

As noted in the modifier definition, you should not append modifier 33 to any code that is already identified as preventive in CPT®. For instance, you shouldn't append modifier 33 to codes such as 99397 (Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older).

Tip: Medicare doesn't recognize modifier 33. Private payers may or may not accept modifier 33, so apply it on an individual basis.

Question 2: Which modifier applies when the physician performed a noncovered service for a Medicare patient, but you didn't get an ABN?

A. Modifier GZ
B. Modifier GY

C. Modifier GX
D. Modifier GG

Answer 2: A. If the physician performed a non-covered service and there's no signed Advance Beneficiary Notice (ABN) on file, you should append modifier GZ (Item or service expected to be denied as not reasonable and necessary) to the CPT® code describing the non-covered service. The advantage to reporting modifier GZ is avoiding the potential for fraud and abuse allegations. This modifier tells Medicare that you know you're submitting the code for a non-covered service, and you expect them not to pay for it.

Be forewarned, however, that modifier GZ claims might be subject to complex medical reviews, which can slow claims and create logjams in your billing processes. However, CMS has a policy to deny those claims instantly.

In black and white: "Effective for dates of service on and after July 1, 2011, contractors shall automatically deny claim line(s) items submitted with a GZ modifier," states Transmittal 2148. Your explanation of benefits will list the denial codes CO (Provider/supplier liable) and 50 (These services are non-covered services because this is not deemed a 'medical necessity' by the payer).

Plan ahead: Don't force yourself to resort to modifier GZ. Have a policy in place to collect ABNs before the procedure or service has been provided, when you think the service will be denied because it doesn't meet the Medicare's medical necessity requirements.

Question 3: A physician intends to perform a bilateral tonsillectomy, but only removes one tonsil. Which modifier should you append to 42821 (Tonsillectomy and adenoidectomy; age 12 or over)?

A. You don't need a modifier.
B. Modifier 52
C. Modifier 53
D. Modifier 51

Answer 3: B. You should use modifier 52 to indicate a partial reduction or discontinuation of procedures and services in other words, when a service is less than the CPT® descriptor or the service is less work than normal. The modifier provides a means for reporting reduced services without disturbing the identification of the basic service.

Since the tonsillectomy code is inherently a bilateral procedure, removing only one tonsil would be a reduced service. In addition, there is no code that describes a unilateral tonsillectomy.

Therefore, you would report this procedure with 42821-52.

Question 4: The surgeon excises a lesion on the right hand and biopsies a different lesion on the patient's left arm. Because of the separate sites, the excision and biopsy are separately billable. Which of the following modifiers do you need to accurately report this scenario?

A. 25
B. 26
C. 58
D. 59.

Answer 4: D. You should append modifier 59 to the biopsy code to show that it occurred at a different location from the excision. Some payers will also require you to use modifiers RT (Right side) and LT (Left side) to accurately describe this scenario.

Question 5: An elderly patient presents for an ingrown toenail (11765). Initially the physician was prepared to have the anesthesiologist administer local anesthesia but within minutes the patient became extremely agitated, in great pain, and required general anesthesia. What modifier should you use?

A. Modifier 23

B. Modifier 47
C. No modifier required
D. Modifier 52

Answer 5: C. You don't need a modifier for this situation. You would just report 11765 (Wedge excision of skin of nail fold [eg, for ingrown toenail]). The coder for the anesthesia provider will take care of the rest.

Modifier 47 (Anesthesia by surgeon) wouldn't be correct because your physician didn't administer the anesthesia and perform the procedure. When the physician performs both anesthesia and surgery, the anesthesia is included in the surgery.

Circumstances when modifier 47 (informational only) wouldn't be used are:

- When an anesthesiologist administers the anesthesia
- For local anesthesia
- If the surgeon is monitoring the general anesthesia being performed by an anesthesiologist, Certified Registered Nurse Anesthetist (CRNA), resident, or intern
- When the surgeon administers the regional or general anesthesia, and the payer you are submitting to is Medicare because Medicare doesn't cover this service
- With a surgical procedure code when the surgeon provides moderate sedation.

Modifier 23 (Unusual anesthesia) is also informational only and you should use it when anesthesiologists, CRNAs, or anesthesiologist assistants (AAs) perform general anesthesia on procedures that are normally performed under local anesthesia or with a regional block.

Even the anesthesia coder would not use modifier 23 with procedure codes that:

- Include the phrase "without anesthesia" in the descriptor.
- Normally are performed under general anesthesia. q
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