Codify by AAPC

Part B Insider (Multispecialty) Coding Alert

MODIFIERS: Learn the Truth About These Three Modifier Myths

Hint: Modifiers 22 and 52 don't take the place of using an unlisted code.

Correct modifier use can make the difference between collecting for your services and finding a claim rejection in your inbox. Get to know the lowdown on these three modifier myths and you'll be on your way to reimbursement success.

Myth 1: Modifier 24 Will Lead to Medicare Payment for Postop Complications. If a patient has a postoperative complication, some practices bill the complication treatment with modifier 24 (Unrelated evaluation and management service by the same physician during a postoperative period) appended.

Reality: You should not use this modifier for Medicare patients' complications, experts say. "Medicare does not pay for complications. Medicare considers complications to be part of the global, even though CPT considers postoperative complications separately billable," says **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CENTC, CHCC,** president of CRN Healthcare Solutions.

According to Medicare, the only time you can collect from Part B for the treatment of a complication is if that complication requires a return to the operating room. "And in those cases you should use modifier 78 (Unplanned return to the operating/ procedure room by the same physician following initial procedure for a related procedure during the postoperative period)," Cobuzzi explains.

"Unlike the AMA definition, which says complications are not part of the global, Medicare says complication care is part of the global and is not billable unless it involves a return to the OR," Cobuzzi says.

Myth 2: If CPT doesn't include a code for a service you provided, you can append modifier 22 or modifier 52 to a different code. Reality: Using modifier 22 (Increased procedural services) or 52 (Reduced services) instead of an unlisted procedure code is a big mistake. Some coders go this route when physicians provide new technology because they realize the payer must manually review such claims and the carrier's computer cannot automatically deny them. But you could be setting your practice up for accusations of incorrect coding and problematic RVUs for a new code when one is finally assigned.

If no precise code exists, you should report the service using the appropriate unlisted procedure or service code.

Plus: If you are coding for a new technology where you have no code to describe what the doctor is doing, you should be using an unlisted code. This way, when CPT advisors develop a new code, they will approve new relative value units (RVUs) as well. If you use an established CPT code with modifier 22 or 52 for the new technology, then RVUs will be stolen from the established CPT code to fund the new code. That is detrimental to the specialty.

Myth 3: If you want to separate Correct Coding Initiative (CCI) edit pairs, modifier 59 is the modifier to use.

Reality: Not necessarily. "First of all, never use modifier 59 (Distinct procedural service) unless you can support that the two codes that are normally bundled were done at different encounters or on separate sites," Cobuzzi says. "If you cannot show this in the documentation, the 59 modifier will not be supported."

Plus: You should never use modifier 59 if another modifier (or no modifier at all) will tell the story more accurately. CPT guidelines indicate that modifier 59 is only appropriate if no more descriptive modifier is available.

In some cases, other modifiers might be more suited for your situation.For instance, if the physician performs an open procedure on the patient's third finger and a percutaneous procedure on the patient's fourth finger, you should append modifier F2 (Left hand, third digit) to 26735, and append modifier F3 (Left hand, fourth digit) to 26727. Because CCI lists

CPT® 2023 American Medical Association. All rights reserved.

Codify by AAPC

the finger modifiers (FA, F1 to F9) as acceptable to use when separating code pairs, you should use them instead of modifier 59 in this case. In some cases, however, your payer may not accept "F" codes -- in that circumstance, you should report modifier 59 instead.

Bottom line: Only append modifier 59 to a claim if you are certain of the distinct nature of the procedures you are reporting, and if no more appropriate modifier exists.

CPT® 2023 American Medical Association. All rights reserved.