Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

MODIFIERS : This Quick Quiz Shows IfYou Suffer From Modifier Misuse

Determine whether you need to hone your modifier coding skills.

Modifiers can make or break your claim, so if your modifier knowledge isnt up to snuff, your practice could be missing out on major reimbursement.

Find out if youre using modifiers to properly code the services your doctors perform with these five quiz questions and answers.

Question 1: Your physician performs a diagnostic endoscopy and, as a direct result of his findings, determines the need for an open surgical procedure. You know you can report the diagnostic endoscopy separately in this case. For Medicare, which modifier do you need to append to the open procedure code?

A. 58

B. 59

C. 78

D. 79.

Answer 1: A. For Medicare payers, you should append modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) to the open procedure to indicate that the diagnostic endoscopy and the open surgical service are staged or planned, says Atlanta-based coding consultant **Jay Neal**.

Pitfall: While modifier 59 (Distinct procedural service) may seem appropriate, the Correct Coding Initiative (CCI) specifically states that if there is another appropriate modifier -- in this case, 58 -- you should use that modifier.

Question 2: During an operative laparoscopic procedure, the doctor determines that he must convert to an open procedure. You should report the open procedure code as well as the laparoscopic procedure code with modifier 53 appended.

A. True

B. False.

Answer 2: B. If the physician converts to an open surgery during a laparoscopic procedure, you should only report the open procedure, according to CPT and CMS guidelines. You should not report the laparoscopic procedure with a modifier, such as 53 (Discontinued procedure), in addition to the open code.

Bonus: If the doctor must spend extra time and effort on the procedure because he converted from lap to open, you may be justified in appending modifier 22 (Increased procedural services) to the open procedure code. Youll need to back up your coding with solid documentation describing in detail the services extensive nature -- for instance, by comparing it to a typical case.

Question 3: A patient with a severe burn received an allograft skin graft 18 days ago. Now the patient is ready to have a partial thickness skin autograft applied as a final treatment. Which modifier should you use when you report the final treatment?

A. You dont need a modifier.

B. 58

C. 78.

Answer 3: B. You should view the final treatment as a staged or planned procedure. Allografts are temporary skin coverings and are not intended to be the final treatment for a burn. You should code the planned return for the autograft using modifier 58 since the procedure is in the global period of the previous allograft treatment.

Question 4: The surgeon excises a lesion on the right hand and biopsies a different lesion on the patients 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, Neal says.Some payers will also require you to use modifiers RT (Right side) and LT (Left side) to accurately describe this scenario.