Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Mythbuster: Abolish These Modifier 27 Myths

Hint: Although this modifier applies to outpatient services, it won't work in the office setting.

You've aced your modifier 25 skills and take great pride in your appropriate use of modifier 22. But there's another modifier in the "20s" that may be more of a mystery to you. Modifier 27 (Multiple outpatient hospital E/M encounters on the same date) may apply to some of your E/M claims and you didn't even realize it. However, you may not know the specifics of this modifier, so read on to bust five of the most common myths about modifier 27.

Myth 1: You Can Use This Modifier in Any Setting

There are times when a patient will need more than one hospital outpatient visit with various physicians on one day. When facing this clinical scenario, you need to inform your payers that the E/M visit performed by your physician is separately reimbursable from the other E/M services on that date. You'll accomplish this by using modifier 27 (Multiple outpatient hospital E/M encounters on the same date).

The purpose of modifier 27 is for you to draw attention to the second outpatient hospital visit in the same hospital or system, so that the second visit isn't thought to be posted in error. Therefore, if the visits were on the same date, in the same facility, 27 would be appropriate. However, this code is not acceptable for use in the physician's office. Only attach modifier 27 to outpatient hospital facility codes and to the second outpatient hospital E/M visit on the same date.

Example: Part B payer NGS Medicare offered the following example of modifier 27 use in its April 2014 webinar, The Outpatient Prospective Payment System Modifier Billing Guidelines: "A patient is seen in the clinic at 8:00 a.m. for a severe headache, receives medication and is sent home after treatment. A claim was submitted with an E/M service. The same patient is seen in ED later that same day at 4:00 p.m. with an uncontrolled nosebleed and is treated. A claim should be submitted and append modifier 27 to the E/M service."

Myth 2: Modifier 27 Can Be Appended to Any Code

Although modifier 27 is helpful for subsequent E/M service billing, you can't append it to non-E/M codes. You should only attach modifier 27 to codes within the following ranges, CMS says in Transmittal A-01-80:

- General ophthalmological services 92002-92014
- E/M codes 99201-99499
- HCPCS codes G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) and G0175 (Scheduled interdisciplinary team conference [minimum of three exclusive of patient care nursing staff] with patient present).

Myth 3: You Should Use the Modifier for Different Hospitals

When one of your patients has two emergency department (ED) visits on the same day, in different facilities from two separate networks, with two separate tax ID numbers, modifier 27 isn't appropriate.

Most hospitals have no way of knowing if there was another emergency department visit earlier in the same day for their patient at a different hospital.

If your patient told your physician that they visited an ED in another hospital earlier that day and your physician documented it, you would only submit for the E/M services provided by your physician in your system.

Example: A patient goes to one ED in the morning for a broken arm and later that same day he goes to a different ED

for chest pain. This is not an appropriate scenario for you to use modifier 27 if the two visits are in separate systems. If the second visit is in the same system as the first, modifier 27 is what you should append to the second E/M claim.

Myth 4: Modifier 25 Is Interchangeable

You might be tempted to rely on modifier 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) to indicate separately identifiable services by two physicians providing concurrent care, but that wouldn't be correct. Modifier 25 is not appropriate to distinguish between two E/M services performed by different providers.

You'll use modifier 25 when the same physician needs to distinguish an E/M visit that is normally bundled into another service, but should not be in your situation.

Myth 5: You Can Skip Condition Code G0

When it comes to Medicare billing, your MAC will typically not pay for modifier 27 unless you pair it with condition code G0 (Two separate and distinct visits provided on the same date of service in the same revenue center, by two different physicians). The G0 code indicates that multiple medical visits occurred on the same day in the same revenue center, and the visits were distinct and independent of each other. Therefore, each visit qualifies for separate reimbursement. Condition codes signify conditions or events that apply to that billing period.

Proper reporting of condition code G0 allows for payment under outpatient perspective payment system (OPPS) in this situation. The outpatient code editor (OCE) contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of condition code G0, according to CMS Transmittal A-01-80.