Welcome. The Webinar will begin shortly.

Disclaimer

Integrity Advantage is presenting this educational coding webinar to providers and partners of BCBSVT on behalf of BCBSVT on the coding guidelines for appropriate use of modifiers 25 and 59.

The material presented in this webinar is for informational/educational purposes only, is not intended to be medical advice or a definitive source for coding claims and is not a substitute for the independent medical judgment of a physician or other health care provider. Health care providers are encouraged to exercise their own independent medical judgment based upon their evaluation of their patients' conditions and all available information, and to submit claims using the most appropriate code(s) based upon the medical record documentation, coding guidelines, and reference materials. References to other third-party sources or organizations are not a representation, warranty, or endorsement of such resources or organizations. The fact that a service or treatment is described in this material, is not a guarantee that the service or treatment is a covered benefit as member contracts vary. Please refer to individual member contracts for details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

Integrity Advantage®

Presents:

Educational Webinar on the Appropriate Use of Modifiers 25 and 59

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About Integrity Advantage

> *Decades* of experience in healthcare payment integrity with state, payers and vendors

> Healthcare payment integrity and Special Investigations Unit (SIU) program support for *niche*

> Services ranging from consulting and program assessments to *outsourced Special Investigations Unit* (SIU) and customized training

> *Highly skilled staff* including Accredited Healthcare Fraud Investigators (AHFI), Certified Fraud Examiners (CFE), Certified Pharmacy Tech (CPhT), Certified Professional Coders (CPC) and Certified in Healthcare Compliance (CHC), Registered Nurses (RN) and Statistician (GStat)

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USWCC EDWOSB Federal
U.S. Women's Chamber of Commerce

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Your Speakers

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Disclaimer

The information provided is current as of 2023 and based on BlueCross BlueShield Vermont (BCBSVT) Provider Handbook and Education Sheets, National Correct Coding Initiative (NCCI) Edits, Current Procedural Terminology (CPT) Manual, and American Medical Association (AMA). Examples provided were taken or derived directly from one of these sources and/or provided by reputable academies or colleges.

Today's Agenda

- Introductions
- Defining Modifiers 25 and 59
- NCCI Guidelines
- Understanding Modifier Overutilization
- Examples
- Resources

What is Modifier 25?

CPT and AMA describe the 25 modifier as a **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.

Definition: *It may be necessary to indicate that on the day a procedure or service identified by a CPT was performed, the patient's condition required a significant, separately identifiable evaluation and management (E/M) service above and beyond that associated with another procedure or service being reported by the same physician or other qualified health care professional (QHP) on the same date. This service must be above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure or service that was performed on that same date and it must be substantiated by documentation in the patient's record that satisfies the relevant criteria for the respective E/M service to be reported.*

Surgical Procedure Guidelines

CPT Manual

CPT Surgical Package Definition: By their very nature, the services to any patient are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services "included" in a given CPT surgical code, the following services related to the surgery when furnished by the physician or other qualified health care professional who performs the surgery are included in addition to the operation per se:

- Evaluation and Management (E/M) service(s) subsequent to the decision for surgery on the day before and/or day of surgery (including history and physical)
- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians or other qualified health care professionals
- Writing orders
- Evaluating the patient in the post anesthesia recovery area
- Typical postoperative follow-up care

Pre- and Post-Operative Services

AMA

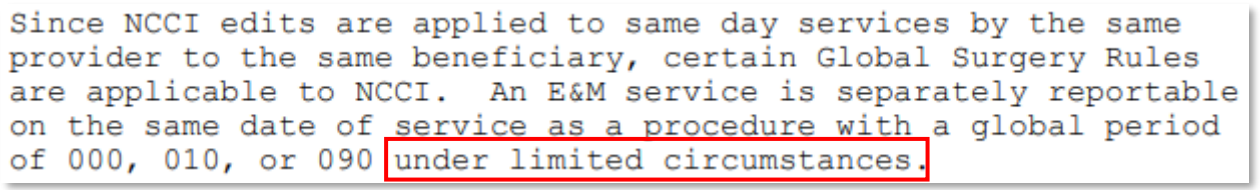
Pre- and post-operative services typically associated with a procedure include the following and cannot be reported with a separate E/M services code:

- Review of patient's **relevant** past medical history,
- Assessment of the **problem area** to be treated by surgical or other service,
- Formulation and explanation of the clinical diagnosis,
- Review and explanation of the procedure to the patient, family, or caregiver,
- Discussion of alternative treatments or diagnostic options,
- Obtaining informed consent,
- Providing postoperative care instructions,
- Discussion of any further treatment and follow up after the procedure.

NCCI and E/M Services

Chapter 1 General Correct Coding Policies:

- Modifier 25 may be appended to E&M services reported with minor surgical procedures or procedures not covered by Global Surgery Rules.
- What is the global period of the service being performed?


Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

- 000, 10-day, 90-day, XXX, MMM, YYY, ZZZ
- New Patients
- 13 chapters of NCCI

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Modifiers that are not listed as informational must be billed in the first position of the modifier field to process correctly.

Modifier 25: Claims are subject to review if there is any question about the E/M being significant and separately identifiable. Office/clinical notes may be requested.

Evaluation & Management (E&M) with Modifier 25 and Surgical Procedure on the Same Day

https://www.bluecrossvt.org/documents/tip-sheet-evaluation-management-modifier-25-and-surgery-same-day

How Do I Know if I Can Append a Modifier 25?

→Did the physician **perform and document the level of medical decision making** or **total time** necessary to report a problem-oriented Office or Other Outpatient E/M service for the complaint or problem?

→Could the work to address the complaint or problem **stand alone** as a reportable service?

→Did the physician perform **extra work** that went above and beyond the typical pre- or postoperative work associated with the procedure code?

Proper Use of Modifier 25 Examples

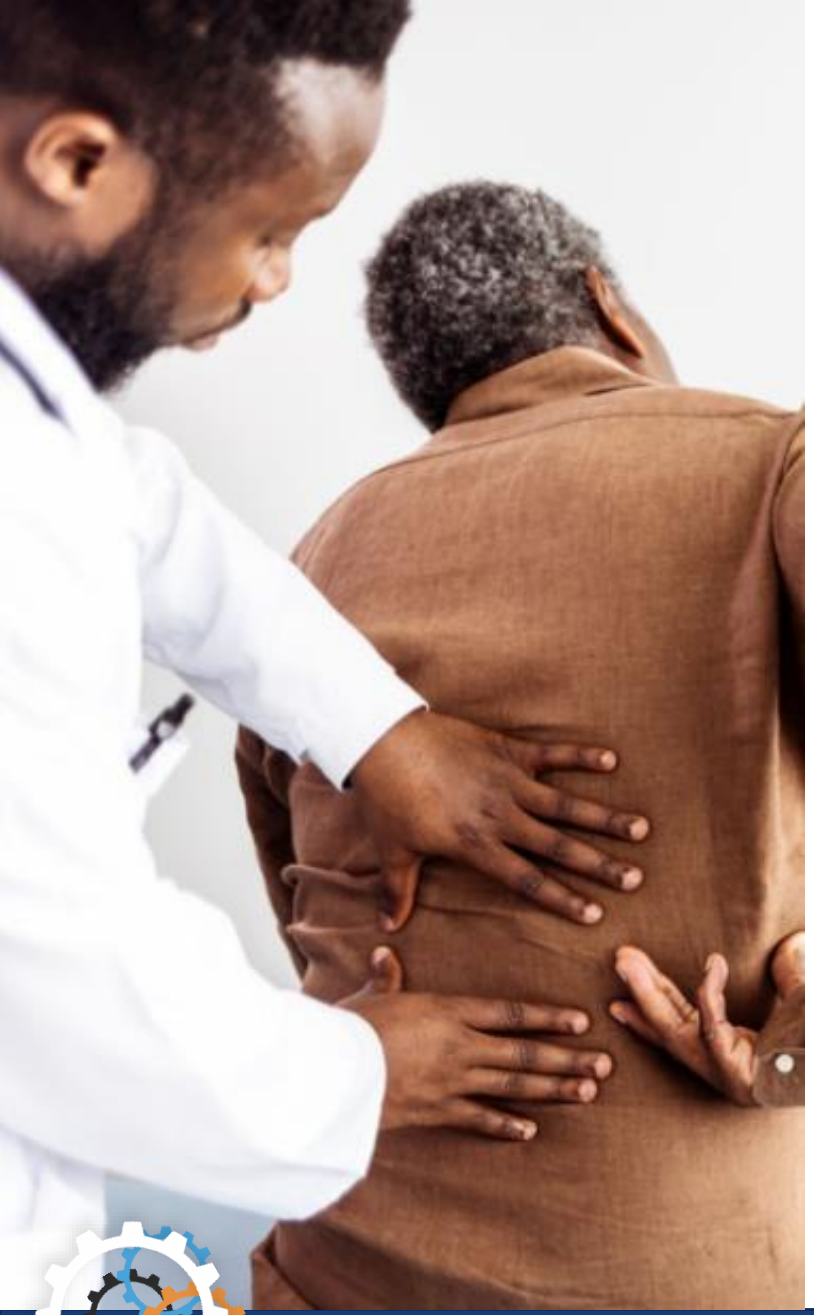
Scenario One: Preventive E/M

A Preventive Medicine E/M service provided with a problem-oriented office evaluation

This is a common scenario.

A 2-year-old is seen for their well child visit. Mother states the child has been pulling on their ear and irritable. The physician does additional workup and finds otitis media during the physical examination.
The medical record documents the elements necessary for both the preventive visit and the diagnostic evaluation.

Modifier 25 allows separate payment for these visits.



Proper Use of Modifier 25 Examples

Scenario Two: Osteopathic Manipulative Treatment (OMT)

Follow-up E/M visit for existing problem previously treated with OMT but with new or different symptoms.

A patient follows up 2 weeks after initial treatment for low back pain. Pain recurred but is now more lateral on the right lower back. The physician evaluates the patient and finds no structural red flags but does find right hypertonic iliolumbar ligament dysfunction. He/she treats with OMT on three body regions and symptoms improve.

Proper coding: E/M code based on level of service plus modifier 25 and CPT code 98926 (OMT on 3-4 body regions)

Proper Use of Modifier 25 Examples

Scenario Three: Acupuncture

A 47-year-old store clerk calls the office of a licensed acupuncturist with complaints of low back pain attributed to length of time standing. During this initial visit, the acupuncturist performs an evaluation and management service to gain history of the condition and discusses treatment options. It is decided that acupuncture to the low back is the best course of action and is rendered at this visit.

Proper coding: E/M code based on level of service plus modifier 25 and appropriate CPT code from range 97810-97814.

(Note if coding the E/M based on time, the time spent in evaluation must be distinct from the time spent performing the acupuncture.)

Proper Use of Modifier 25 Examples

Scenario Four: Lesion

An established patient presents with a growing lesion on the nose. In addition, the patient reports multiple enlarging growths on the back and dense scaly lesions on a bald scalp. A suspected basal cell carcinoma on the nose is tangentially biopsied using the tangential/shave technique. In addition, the patient is reassured that the lesions on the back are seborrheic keratoses that do not require treatment; however, the patient was diagnosed with diffuse scalp actinic keratoses for which topical 5-fluorouracil cream treatment is prescribed and the treatment plan is discussed.

Proper coding: CPT 11102, Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion, would be reported for the biopsy. CPT 99213, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making, would be reported with modifier 25 appended to indicate that a significant, separately identifiable E/M service was provided.

While the evaluation and management associated with the suspected basal cell carcinoma is included in the global package for the skin biopsy code, the management of multiple enlarging growths on the back and the scaly lesion on the scalp may be reported as a separate E/M service.

Improper Use of Modifier 25

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Improper Use of Modifier 25

Scenario One: Preventive E/M

A Preventive Medicine E/M service with additional concern from the parent.

An 18- month-old is seen for a preventive visit. During the visit, the mom mentions the child has diaper rash and she is using ointment to relieve the symptoms. The provider reassures her she is taking the correct action. The provider notes this along with the elements for a preventive visit in the medical record.

In this case, the rash was an insignificant or trivial problem, and the provider did not perform additional workup for the condition. It would not be appropriate to bill an E/M CPT with a 25 modifier.

Improper Use of Modifier 25

Scenario Two: Osteopathic Manipulative Treatment (OMT)

OMT procedure for existing problem

Patient follow up four weeks after treatment for low-back pain that improved but did not resolve with previous OMT. Pain has not worsened since last OMT. Physician again finds right hypertonic iliolumbar ligament dysfunction. Treats with OMT on three body regions and symptoms improve.

The brief evaluation performed to assess the low-back pain was not separate, nor significant enough to support billing an E/M code. Only bill 98926 (for OMT on 3-4 body regions).

Improper Use of Modifier 25

Scenario Three: Cardiovascular Study

A patient is scheduled to come into the office for a cardiovascular stress test. The physician completes a history related to the condition and performs a limited examination (specifically related to the stress test)

Only the code for the cardiovascular stress test would be supported. The history and exam are related to the condition the member is being seen for and there is no indication of an additional concern.

Improper Use of Modifier 25

Scenario Four: Injections

A patient returns for a second injection in a series of three. The provider documents an appropriate history and exam related to the condition prior to giving the injection. There are no new issues or concerns addressed.

As this was a predetermined procedure with no additional workup above and beyond that necessary to perform the injection. The billing of an E/M with modifier 25 would not be appropriate.

Avoiding Overutilization of Modifier 25

- ✕ Do not use a 25 Modifier when billing for services performed during a postoperative period if related to the previous surgery.
- ✕ Do not append Modifier 25 if there is only an E/M service performed during the office visit (no procedure done).
- ✕ Do not use a Modifier 25 on any E/M on the day a “Major” (90 day global) procedure is being performed.
- ✕ Do not append Modifier 25 to an E/M service when a minimal procedure is performed on the same day unless the level of service can be supported as significant, separately identifiable. All procedures have an “inherent” E/M service included.
- ✕ Do not use modifier 25 if patient came in for a scheduled procedure only.

Modifier 59

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What is Modifier 59?

CPT describes the 59 modifier as **Distinct Procedural Service**.

Definition: Under certain circumstances, it may be necessary to indicate that a procedure or service was **distinct or independent** from other non-E/M services performed on the same day. **Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances**. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service.

NCCI

Chapter 1: General Correct Coding Policies

- Modifier 59 is an important NCCI PTP-associated modifier that is often used incorrectly. For the NCCI program, its primary purpose is to indicate that 2 or more procedures are performed at different anatomic sites or different patient encounters. One function of NCCI PTP edits is to prevent payment for codes that report overlapping services, except in those instances where the services are “separate and distinct.” Modifier 59 shall only be used if no other modifier more appropriately describes the relationships of the 2 or more procedure codes (see Section E for modifiers -X{EPSU})

NCCI Examples

Chapter 1: Coding Based on Standards of Medical/Surgical Practice

Most HCPCS/CPT code defined procedures include services that are integral to them. Some of these integral services have specific CPT codes for reporting the service when not performed as an integral part of another procedure. For example, CPT code 36000 (Introduction of needle or intracatheter, vein) is integral to all nuclear medicine procedures requiring injection of a radiopharmaceutical into a vein. CPT code 36000 is not separately reportable with these types of nuclear medicine procedures. However, CPT code 36000 may be reported alone if the only service provided is the introduction of a needle into a vein. Other integral services do not have specific CPT codes. (For example, wound irrigation is integral to the treatment of all wounds and does not have a HCPCS/CPT code.) Services integral to HCPCS/CPT code defined procedures are included in those procedures based upon the standards of medical/surgical practice. It is inappropriate to separately report services that are integral to another procedure with that procedure.

NCCI Examples

Ch. 7 Surgery: Urinary, Male Genital, Female Genital, Maternity Care and Delivery Systems

If a diagnostic endoscopy leads to the performance of a laparoscopic or open procedure, the diagnostic endoscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic endoscopy and non-endoscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic endoscopy. However, if an endoscopic procedure is performed as an integral part of an open procedure, only the open procedure is reportable. If the endoscopy is confirmatory or is performed to assess the surgical field (“scout endoscopy”), the endoscopy does not represent a separate diagnostic or surgical endoscopy. The endoscopy represents exploration of the surgical field and shall not be reported separately with a diagnostic or surgical endoscopy code.

NCCI Exceptions

- When a diagnostic procedure **precedes** a surgical or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical or non-surgical therapeutic procedure is made, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; and (c) it does not constitute a service that would have otherwise been required during the therapeutic intervention. If the diagnostic procedure is an inherent component of the surgical or non-surgical therapeutic procedure, it shall not be reported separately.
- When a diagnostic procedure **follows** a surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have otherwise been required during the therapeutic intervention. If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it shall not be reported separately.

What are the X Modifiers and When do I Use Them?

XE: Separate Encounter, a service that is distinct because it occurred during a separate encounter

XS: Separate Structure, a service that is distinct because it was performed on a separate organ/structure

XP: Separate Practitioner, a service that is distinct because it was performed by a different practitioner

XU: Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service

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BCBSVT **considers 59 a payment modifier**. Their directive is that the record must clearly indicate the circumstances for reporting with this modifier and only used when no other valid modifier applies.

According to the Education sheet for BCBSVT, providers may use either 59 or the “X” modifiers.

https://www.bluecrossvt.org/documents/modifier-59-tip-sheet

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Using modifiers 59 or XS properly for different anatomic sites during the same encounter only when procedures which aren't ordinarily performed or encountered on the same day are performed on:

- Different organs, or
- Different anatomic regions, or
- In limited situations on different, non-contiguous lesions in different anatomic regions of the same organ

Modifiers 59 or XS are for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that:

- Are performed at different anatomic sites,
- Aren't ordinarily performed or encountered on the same day, and
- Can't be described by one of the more specific anatomic NCCI PTP-associated modifiers – that is, RT, LT, E1-E4, FA, F1-F9, TA, T1- T9, LC, LD, RC, LM, or RI. (See examples 1, 2, and 3 below.)

https://www.bluecrossvt.org/documents/modifier-59-tip-sheet

Modifier 59/XU Examples

Scenario One: Adolescent Screening

A 14-year-old boy presents for his annual preventive visit. During this visit the boy and his parent fill out a PHQ-9 behavioral assessment and a CRAFFT health risk assessment. The provider performs the evaluation and scores the assessments documenting his findings. The assessments are retained in his medical records.

CPT 96160-59 for the CRAFFT screening is billable with 96127, PHQ-9 screening and 99394 Periodic comprehensive preventive medicine reevaluation and management for a 14-year-old.

Modifier 59/XS Examples

Scenario Two: Nail Debridement

A patient presents to the office for foot care. It is noted that the nails are long and thick. There are hyperkeratotic lesions on the right and left heels and on the left second metatarsal head. The podiatrist debrides all ten nails and trims three lesions. It is appropriate to bill for the debridement of the nails using modifier 59 and trimming of the lesions.

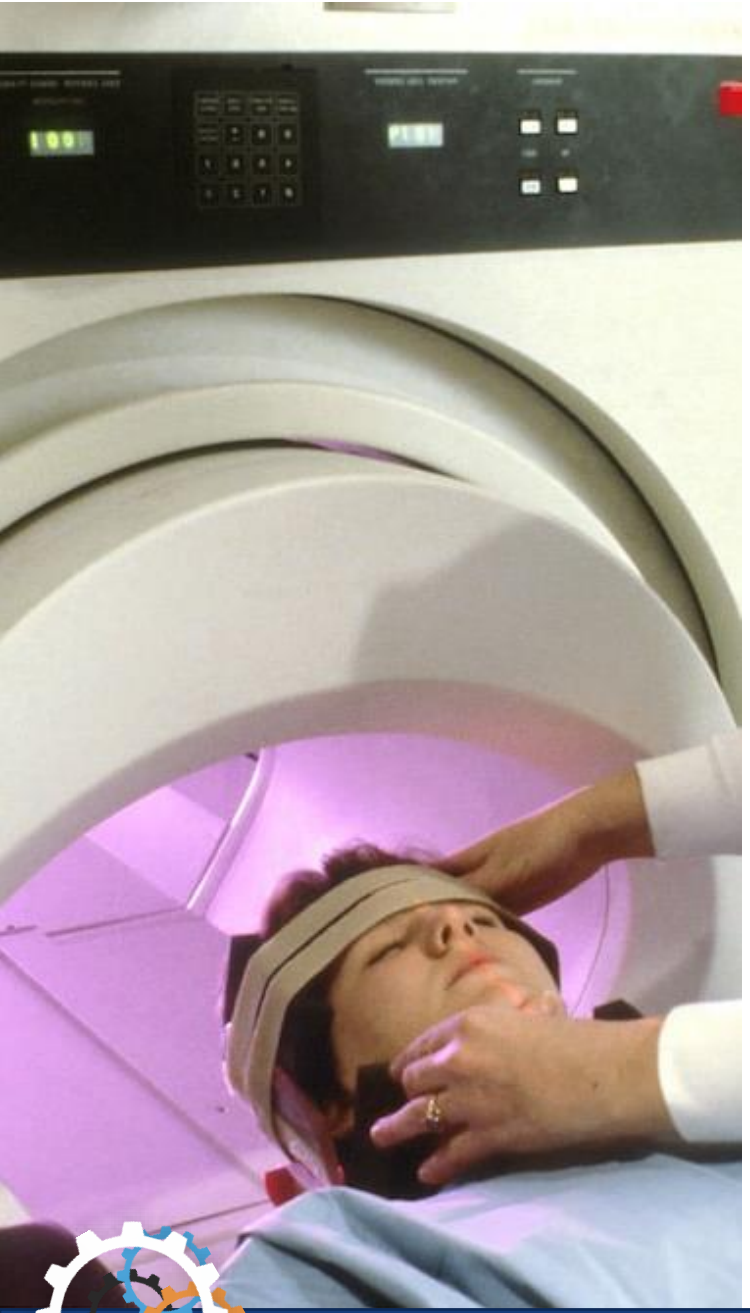
NCCI instruction excludes nail debridement with trimming of the lesion if it is on the same distal phalanx.

Modifier 59/XE Examples

Scenario Three: ECG

A patient presented for cardiovascular stress test using a treadmill. The patient received pharmacological stress and continuous electrocardiographic monitoring. The provider supervised the test and at its completion documented their interpretation and generated a report.

In this instance the ECG is a component of the procedure performed and not separately billable, if the rhythm ECG was performed at a different encounter the same day as the cardiovascular stress test and separately supported. You may report modifier 59 or XE.



Modifier 59/XU Examples

Scenario Four: MRI/MRA

A 67-year-old woman is seen by her physician for complaints of a severe headache, dizziness, and trouble with her vision. She has a past history of TIA. The physician orders an MRI and MRA of the brain. She presents to the Imaging department and is placed on the table where an MRI and the MRA are performed consecutively.

Modifier 59 is not appropriate in this circumstance. A single technical study was used to generate images for two different reports.

NCCI instructs that MRI and MRA may be separately reportable if they are performed at separate encounters, or two distinct studies were performed. They also clarify that medical necessity for the two distinct studies being performed at the same encounter is an uncommon situation.

Modifier 59/XS Examples

Scenario Five: Chiropractic

Appropriate Use: The patient presented with thoracic and shoulder pain. Manipulation was performed to the spine and manual therapy was performed to the shoulder area. 97140 is separately reportable as the manual therapy was performed to an area that did not have spinal manipulation.

Inappropriate Use: The patient presented with cervical and thoracic pain. Spinal manipulation was performed to all spinal regions as well as manual therapy was performed to the cervical region. CPT® code 98942 is the only service that should be reported as manual therapy (97140) was performed to the same region that also received CMT.

Takeaways

25

Modifier 25

Significant and Separately Identifiable

59

Modifier 59 (X)

Different session, procedure/surgery site/organ system, separate incision/excision, lesion, injury

Application

Do not apply a modifier only to bypass edits

Documentation

Documentation is the key to supporting modifiers 25 & 59

References

https://www.bluecrossvt.org/documents/modifier-25-tip-sheet

https://www.bluecrossvt.org/documents/modifier-59-tip-sheet

https://www.bluecrossvt.org/documents/tip-sheet-physical-medicine-codes-chiropractic-manipulative-treatment

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https://www.bluecrossvt.org/sites/default/files/2023-09/Chiropractic%20Services%20-%202023%20-%20PUBLICATION%2010.01.2023-AM.pdf

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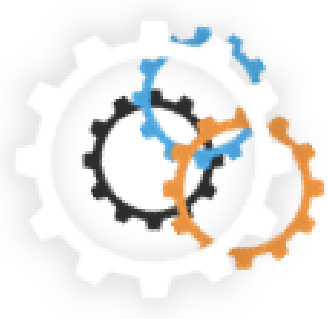
References

We'd like to invite you to review BlueCross BlueShield of Vermont's website.

- Provider News & Updates
- Provider Policies
  - Vermont Medical Policies
  - Provider Appeal and Contracts Policies
  - Provider Payment Policies
  - Clinical Practice Guidelines
- Provider Forms & Resources
  - Coding Tip Sheets
  - Additional Resources
    - Provider Handbook

https://www.bluecrossvt.org/providers/provider-policies

THANK YOU!



Q & A