26th EAST Annual Scientific Assembly
Sunrise Session #7
Billing and Coding the
Complex Acute Care Surgical Cases
January 17, 2013

Presenters
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CASE ONE

74 yr old male presents to the ED with abdominal pain and bowel distension. On Coumadin for cardiac issues, INR 4.2. Elevated lactate, mild acidosis on ABG, Hgb is high (hemoconcentrated) CT shows distended large bowel with some pneumatosis. Working diagnosis is bowel ischemia – possible necrosis. Decision to take patient to the OR, actively resuscitated prior to this in the ICU for 3 hours with fluid, FFP to correct INR.

Taken to the OR, cecum found to be necrotic with a small perforation. Rest of the large intestine dilated and unhealthy looking. Sub total colectomy done. Patient is marginally stable in the OR, requiring a lot of fluid bolus (and occasional neosynephrine boluses by anesthesia!!) Abdominal vac placed with the ends of the bowel stapled closed and patient taken back to the ICU for resuscitation and further management.

Two days later, the sun is shining brighter, patient is normotensive, not on any pressors, not requiring fluid boluses, adequate urine output. He is taken back to the OR where an end ileostomy and a gastrostomy feeding tube is placed. Fascia is closed, skin left open, patient taken back to the ICU.

Post op day 8, patient has been extubated for 24 hours now. Awake, a bit somnolent, decision made to send him to the floor. Nurse notes bed is soaked. Examining the incision, the wound has dehisced with small intestine lying in the bed next to the patient.

He is taken back to the OR. The fascia is weak and not holding sutures well. It is felt that a repeat dehiscence would likely occur. A biological mesh is placed to bridge the gap – (Alloderm) and a vac placed on top of this.

Patient tolerates this procedure well, 1 week later is about to be discharged to a nursing home. But wait …..

Before discharge, he is noted to have a Rt femoral DVT, Coumadin restarted with a lovenox bridge. He develops bleeding from his ostomy with a 3 point drop in hemoglobin. Upper GI endoscopy by GI shows an ulcer which is heated probed – no further active bleeding. The surgeon then decides to place an Inferior Vena Cava filter prior to patient's discharge. Procedure goes well and the patient is finally discharged from the hospital.

I billed first for an admission – 99223, then ICU critical care time for the ICU portion 99291, 99292. Then for a sub-total colectomy (44150) and a VAC placement (97606)

For the second look operation billed 49002 for reopening of the abdomen and 43830 for gastrostomy (although I don't think they will pay for both!)

For the dehiscence with mesh placement billed 15271 or 15130

For the IVC filter billed 37191

Suggested Coding: Bill a 99291 for the ED care and then the appropriate number of 99292 units to account for subsequent critical care time. Critical care codes depend on the intensity of service not the venue in which they are rendered.

A 52 modifier should be used for the sub-total colectomy (44150). The VAC (97606) does not require a modifier but does require documentation of wound size (>50 sq. cm.)

For the 2nd look: don't bill a 49002, but rather a 44310 (creation of ileostomy) with 58 modifier and 43830 (gastrostomy) with 79 modifier.

For the dehiscence: 13160 (secondary closure of surgical wound/dehiscence)with addon code 15777 for use of mesh.

For the IVC filter (37191), a 79 modifier is required.

How to bill for:

1. Incisional hernia repair *with mesh* (code 49568 indicates that the abd closure is for necrotizing soft tissue infection)

Suggested coding: 49568 is appropriate, no modifier necessary. Remember to apply appropriate modifier when indicated.

2. Complex abdominal wall closure or secondary abd wall closure (is 49900 the correct code?)

Suggested coding: Use of 13160 is more appropriate and garners more RVUs

3. Abdominal washout/vak change (is 49020 with 97606 the best code?)

Suggested coding: Use49002 with 58 modifier then 97606 documenting wound size without any modifier.

4. Colon resection (when bowel is left in discontinuity) (44140 code includes "with anastomosis")

Suggested coding: 44140 is appropriate but using a 52 modifier (reduced service—i.e. no anastamosis)

5. Colon anastomosis (or small bowel anastomosis) when the bowel has previously been resected and in discontinuity and will now be reanastomosed without further resection (code 44140 includes resection)

Suggested coding: Use 44130 (enteroenterostomy) with 58 modifier

CASE TWO

This is a case of a 63-year-old male with a history of laparoscopic transabdominal right inguinal hernia repair, right nephrectomy, prostatectomy, cystectomy with ileal neobladder reconstruction and right to left femoral to femoral bypass graft. He presented with an incarcerated recurrent right inguinal hernia causing a high-grade bowel obstruction. We started with a right groin approach to the hernia, avoiding the fem-fem graft. Dense adhesions made the hernia unable to be reduced. Multiple loops of intestine were densely adherent to the hernia sac down into the right scrotum. An enterotomy resulted from the extensive dissection and adhesiolysis. At this point we performed a midline laparotomy to reduce the bowel and examine it thoroughly. Extensive dissection was required to reduce the bowel from the hernia defect. Small bowel resection was performed due to dense adhesions and the enterotomy performed during dissection. This was only a few centimeters from the ileocecal valve, resulting in ileocecectomy. Inguinal hernia repair was performed with bioprosthetic mesh. The entire procedure with extensive lysis of adhesions took approximately 5 hours. This was coded as open right inguinal hernia repair with bioprosthetic mesh, exploratory laparotomy with extensive lysis of adhesions and ileocecectomy with anastomosis. Does this justify the 22 modifier due to prolonged operation? Blood loss was not overall very significant. Is there any way to more clearly described and code these extremely prolonged reoperative cases that require lysis of adhesions and complex approaches?

Answer: Very appropriate to use 22 modifier. Unfortunately you can not bill for the lysis of adhesions, but can do so for the hernia with mesh and bowel resection. Documentation is key here, noting that due to the extensive adhesions and altered surgical field (no longer a modifier) it was not possible to repair the hernia without resecting bowel.

Questions?

Use of advanced practitioners in the ICU. Can they bill in the same 24 hour period that you as a critical surgeon would bill for the initial or subsequent daily critical care rounding. I ask this because we are moving towards 24hour coverage in the ICU by Advanced Practitioners and need to justify their expense. This also includes residents at night.

Answer: Advanced practitioners can bill for subsequent critical care visits the same as for physicians. The key as to whether they can bill a 99291 or 99292 for a first subsequent visit rests on whether they have the same or different billing number from the physician (or practitioner) that preceded them. Subsequent visits of their own, or from the physician or practitioner seeing the pt earlier, should generate a 99292 with appropriate time documentation. Remember that after midnight starts a new billing cycle and therefore the first critical care service after midnight should generate a 99291 even if care by the same provider was rendered on the same call shift, but before midnight.

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Billing and Coding Complex Emergency Surgical Cases

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Billing and Coding

An Art and a Science

- Not Bilking the System
- Not Gaming the System

- Getting your 'just due'
- Beating them at their own game

WHEN IN DOUBT

- Submit
- Track
- Appeal

(Know your CMS contact)

WHAT'S IT WORTH TO YOU

Procedure	CPT	WRVU
Ex Lap	49000	12.54
Re-Opening Lap	49002	17.63
Retroperitoneal Expl	49010	16.06
IVC Filter	37191	4.71
Abd Wall Reconst with Flaps	15734	19.86
CVP Line	36556 (5)	2.50
➢ Exchange	36580	1.31
➢ U/S Guided	76937	0.30
➢ Fluro	77001	0.38

WHAT'S IT WORTH TO YOU

Procedure	CPT	WRVU
PEG ➢ Laryngoscopy	43246 31525	4.32 2.63
Bladder Pressure	51725 (6)	1.71
Compartment Pressure ABI VAC <50 sq cm >50 sq cm	20950 93922 97605 97606	1.26 0.25 0.55 0.60
Perc Trach ➢ Bronch	31730 31622	2.85 2.78
Open Trach	31600	7.19

WHAT'S IT WORTH TO YOU

Procedure	CPT	WRVU
Conscious Sedation ➢ 1st 30 min ➢ Additional 30 min	 99144 99145	 XXX XXX
Ligate Mesenteric Vessel	37617	23.79

Lysis of Adhesions CPT - 44005

- Can Use

No other procedure

- Can't use

Any other procedure during laparotomy

MODIFIERS

WHICH, WHEN, WHY

E & M Modifiers

- 57 – Denotes decision for surgery day of or day before. Global period starts after E&M with 57.
- 24 – Denotes unrelated E&M service. Prevents denial of post-op visits. Post-op E & M must be for different dx/ICD-9 than the primary dx, i.e. unrelated to original procedure.
- 25 – Denotes significant separately identifiable E & M on the day of a procedure. Allows billing for both E & M and the subsequent procedure.

CPT MODIFIERS

- 51 – Multiple procedures. Apply to procedures other than the primary procedure. Allows multiple CPTs to be accepted rather than denied.
- 59 – Distinct procedural service. Identifies procedures usually not reported together to prevent them from being considered as bundled under the primary procedure.
  - a) different session
  - b) different procedure or surgery
  - c) different site or organ system
  - d) separate incision/excision
  - e) separate injury

CPT MODIFIERS

- 58 – Staged (i.e.planned) or related procedure during post-op/global period. Allows full payment for follow-up operation(s) (no reductions). Begins a new post-operative/global period. No fee reduction.
- 78 – Unplanned return to OR following initial operation for a related procedure during global period (e.g. complications from first operation). Does not start new global period. Partial fee reduction.
- 79 – Return to OR for unrelated procedure during global period of a previous operation. Starts new post-op period. No fee reduction.

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CPT MODIFIERS

- 52- Reduced Service. Partial performance of a procedure (e.g. leaving bowel in discontinuity). Informational only. No fee or RVU reduction.
- 53- Discontinued Service. Unsafe to proceed with the procedure. Allows payment for procedure.

CPT MODIFIERS

- 62 – Two surgeons. Same specialty vs different specialty (carrier dependent) complete single procedure but perform separate distinct parts. Specific documentation essential. Allows partial payment to both surgeons (fee splitting). ??? Politics
- 82 – Assistant surgeon. No qualified surgical resident. Allows assistant fee. (NP/PA?)

CPT MODIFIERS

- 22 – Increased Procedural Services. Procedure requires substantially more effort/time than usual. Documentation essential (extra time and reason why – technical difficulty, patient severity, physical & mental effort).
  - Allows 15 – 30% (hospital dependent) fee increase
  - Subject to closer scrutiny
  - Delays payment

CASE STUDY #1

You are consulted on an in-patient with Head and Neck Cancer for a feeding gastrostomy. You decide to attempt a PEG in the OR, on the same day. Initial attempts to intubate the esophagus are difficult and you utilize laryngoscopy, intubate the esophagus but can not pass the scope past the cricopharyngeus. You abort further attempts at endoscopy and proceed to open G-Tube.

CASE #1 – Coding Options

- a) In-patient consult (99255)
  - Modifier 25 + 57
- b) Upper endoscopy/PEG (43246)
  - Modifier 53/52
- c) Laryngoscopy (31525)
  - Modifier 59
- d) Open G-Tube (43830)
  - +/- Modifier 22
- Best Option – a) with 25 and 57 modifier, then d) using 22 Modifier. (WRVU 14.85)

CASE STUDY #2

A young male is shot multiple times in the trunk at 11:00 PM. You spend 35 minutes evaluating and resuscitating him in the ED. You perform a FAST, personally intubate him, do an ABI because of diminished pulses and place a central line with the aid of ultrasound. You then take the patient for a laparotomy.

CASE #2 – CODING OPTIONS

E & M 99291, 99285, 99223, none

Modifiers – 25, 57, none

Procedures

CVP Line – 36556, 76937, both, none

Modifiers – 59, 51, none

Intubation – 31500

Modifiers – 59, 51, none

ABI – 93922

Modifiers – 59, 51, none

FAST – 76700

Modifiers – 59, 51, none

CASE #2 - Suggested Coding

- E & M = 99291 + 25 + 57
- Procedures = 31500, 36556 +51, 76937, 76700, 93922
- **Total WRVU = 15.19**

CASE #2 - Continued

- At laparotomy you perform a splenectomy, small bowel resection x2, leaving bowel in discontinuity, explore a left perinephric hematoma with packing, ligate a mesenteric bleeder in the transverse mesocolon and staple across an anterior gastrotomy. You also ligate the right iliac artery and vein and ask a vascular colleague to assist in placing an iliac arterial shunt. You place a VAC and bring the pt to the ICU at 2am and spend another 90 min resuscitating him.

CASE #2 - QUESTIONS

- What can you bill for from the operation:
  - Additional critical care in the OR
  - Additional critical care post op in the ICU
    - What ICD-9 Codes (different/same)
    - What and how many units (99291, 99292)
  - Ex Lap (49000)
  - Bowel resection x2 (44120 x1, 44120 x2), modifier?
  - Retroperitoneal Exploration (49010) Modifier?
  - Ligation Iliac artery (37617) Modifier?
  - Ligation Iliac vein (35221) Modifier?
  - Ligation Mesenteric Vessel (35221) Modifier?

CASE #2 – QUESTIONS (cont)

- Repair of gastrotomy (43840) Modifier?
- Placement of arterial shunt (36147)
  - Vascular Surgeon? Modifier?
- Application of VAC device (97606) Modifier?

CASE #2 – SUGGESTED OPTIMAL CODING

Procedure	CPT	WRVU
Post-Op Critical Care	99291 + 99292, 24 (518.5, 958.4)	6.75
Ex Lap – NO		XX
Splenectomy	38100, 59	19.55
Bowel Resection	44120,51,52; 44120, 51, 52	20.83 x2
Retroperitoneal Exploration – NO		XX
Ligation Mesenteric Vessel	35221	26.62
Ligation Iliac Vein	35221, 59	26.62
Ligation Iliac Artery	37617, 51	23.79

CASE #2 – SUGGESTED OPTIMAL CODING

Procedure	CPT	WRVU
Repair Gastrotomy	43840, 51	22.83
Arterial Shunt	36147, 62	3.72
VAC Appliction	97606	0.60
		Total WRVU = 172.14

CASE #2 - CONTINUED

- Your colleague (same specialty -Trauma Surgeon) sees the patient on morning rounds at 7:00 AM for 45 minutes and then again at noon for another 45 minutes at which time she decides to take the patient back to the OR to re-vascularize his lower extremity and remove packs.
- At that second laparotomy she restores small bowel continuity, removes peri-nephric packs and consults Urology, who do a hemi-nephrectomy with her assistance. Vascular Surgeons then perform an interpolation graft on the iliac, with her help. She performs a feeding jejunostomy, distal to anastamoses and a 4 compartment fasciotomy after checking compartment pressures. She re-applies the VAC and finally performs a percutaneous trach with bronchoscope guidance. The patient returns to the ICU at 4:00PM.

CASE #2 – QUESTIONS

- What can/should she bill for?
  - Critical Care – 99291, 99292 (#? Modifier?) RVU = 4.5/2.25
  - Re-exploration – 49002
  - Small bowel anastamoses – 44130 (x1, x2, Modifier?) RVU = 22.11
  - Removal of retroperitoneal packing
  - Hemi-nephrectomy – 50240 (Modifier?) RVU= 24.21

CASE #2 MORE QUESTIONS

- Re-vascularization of LE - CPTXXX (Modifier?)
- Measurement of Compartment Pressures
- Fasciotomy – 27602 (Modifier?) RVU= 7.82
- Feeding Jejunostomy – 44015 (Modifier?) RVU = 2.62
- Bronchoscopy – 31622 (Modifier?) RVU= 2.78
- Perc trach – 31730 WRVU – 2.85

CASE #2 – SUGGESTED OPTIMAL CODING

Procedure	CPT	WRVU
Critical Care	99292 – 24, 57 x3	6.75
SB Anastamoses	44130 – 58; 44130-58,59	44.22
Fasciotomy	27602 – 79, 51	7.82
Trach	31730	2.85
VAC	97606	0.60
Bronchoscopy	NO – BUNDLED	XXX
Interposition Graft		
Hemi-nephrectomy	50240	24.21
Opening recent lap	49002 - NO	
Retroperitoneal Expl/Packing removal	NO	
		Total WRVU = 86.45

CASE #2

- Finally, you are called to the bedside at 5:00PM because the colleague who just operated is back in the OR with another trauma patient. The patient is hypoxic and hypotensive. You are there for 90 minutes and perform bronchoscopy, do an ultrasound to assess volume and cardiac function, along with potential pneumohemothorax and then decide to place a Swan Ganz catheter through an existing subclavian cordis introducer.

CASE #2 - QUESTIONS

- What can/should you bill for?
  - Critical Care (99291, 99292, Modifier?, none)
  - Ultrasound (76700, 76604, both, neither, modifier)
  - Swan Ganz (93503, Modifier?, No Charge?)
  - Bronchoscopy (31622, Modifier?)
  - What ICD-9 code(s)

CASE #2 – SUGGESTED OPTIMAL CODING

Procedure	CPT	WRVU
Critical Care	99292 – 24, 25 x3	6.75
U/S Abdomen	76700	0.81
U/S Chest	76604	0.55
Bronchoscopy	31622 - 51	2.78
Swan Ganz	93503	2.91
		Total WRVU = 13.8

CASE #3

- You perform a Hartman's procedure on an insulin dependent diabetic. Post-op, while he is on a surgical floor, you manage his blood glucose and adjust insulin dose daily.
- Is this care included in the global package?
- If not, how do you bill for this post-op care?

CASE #3 – OPTIONS FOR CODING

- CPT – None, 99291, 99233
  - Modifier – none, 24, 25, 59, other?
- ICD-9 – 250.0, 790.6, 562.11
- SUGGESTED
  - 99233 – 24 using 250.0 ICD-9
- WRVU = 2.00

CASE #3b

- In a similar patient who is NOT diabetic, on post-op day 3 the colostomy is still not productive, there are no bowel sounds and the NG output is 1.5 liters.
- How do you bill for his post-op care?

CASE #3b
OPTIONS FOR CODING

- CPT – none, 99291, 99233
  - Modifier – none, 24
- ICD-9 – 997.4, 263.8, 562.11

- **SUGGESTED**
- **99233 – 24, using ICD-9 - 997.4**

Indiana University Health

Billing and Coding in the ICU and ED

R. Lawrence Reed, II, MD FACS FCCM
Director of Trauma Services, IU Health Methodist Hospital
Professor of Surgery, Indiana University
Indianapolis, IN

My assigned tasks

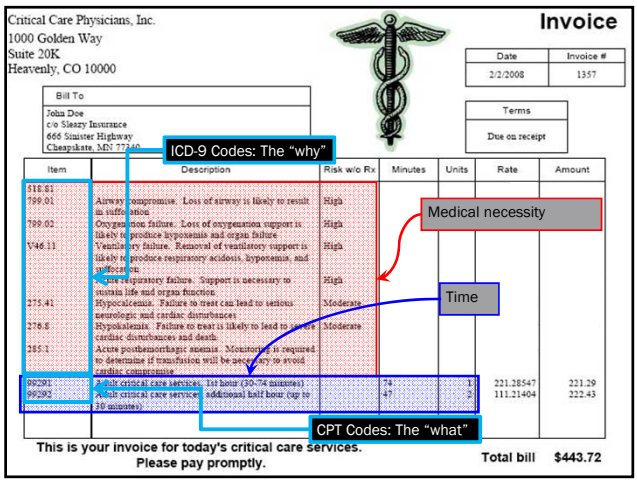
- Necessary components for billing critical care time
- Billing moderate sedation and procedures
- Billing E and M codes vs critical care time in the ED
- How to properly bill the patient who arrives as a trauma alert, but goes home from the ED
- Billing with acute care practitioners/midlevel providers

Necessary components for billing

- Billing anything requires:
  - Appropriate & adequate documentation, whether service (i.e, E&M) or procedure
  - ICD-9 code (for now)
    - Always use the code with the largest number of digits, if possible (i.e., 560.81 should be used instead of 560.8)
  - CPT code
  - ± modifier(s) for billing peri-procedural care

Documentation for adult critical care CPT codes: 99291 & 99292

- Requirements for critical care billing using 99291 & 99292
  - Medical necessity
  - Time
  - In perioperative (global) period:
    - a diagnosis justifying the critical care that is different from the operative diagnosis
    - a modifier to indicate the critical care is not bundled into the global package payment
- Your note must reflect these items to justify payment
- Think of your note as your invoice



Your Note is Your Invoice: Medical Necessity

- Critical care is defined as the care of critically ill or critically injured patients who require the full & exclusive attention of a physician
- Critical illness or injury is defined as one that acutely impairs one or more vital organ systems such that there is high probability of imminent or life threatening deterioration in the patient's condition.
- The mere presence of a patient in an ICU or CCU, or the patient's use of a ventilator, is not sufficient to warrant billing critical care services
- Documentation should support that patient is critically ill and receiving critical care
- Wherever possible, indicate the consequences if the patient were not receiving critical care

Your Note is Your Invoice: Time

- Adult critical care daily visits are time-based codes
- Physician progress note must contain documentation of the total time involved providing critical care services
- Must be the actual time spent by the physician, not a resident, fellow, or allied health provider
- The time must be personally documented by the billing physician
- Teaching time does not count toward critical care time
  - Asking questions of the team for diagnostic and treatment options does count
- Critical care of less than 30 minutes duration on any given day is reported with an evaluation and management code.

Your Note is Your Invoice: Time

- 99291 and 99292 are used to report the total duration of time spent in critical care E&M
- Time must be exclusive
  - Time cannot be shared with another patient
  - Time cannot include time spent on procedures that are billed separately
- Time does not need to be continuous; should total all interrupted segments
- Total time must be documented in the chart

A poor note on an unstable ICU patient

"Pt. w/severe resp. failure. ↑F_iO_2 to 80% w/PEEP 15. CXR w/diffuse bilat. infiltrates. Still bleeding d/t coagulopathy. Xfused 4U PRBCs over 24°, along with FFP & cryo. On Epi & dobs w/BP in 90s. Will supp K^+, Ca^{++} & Mg^{++}. Consider Xygress."

Avoid abbreviations!!!

The note is not the only thing that's hopeless!!!

A poor note on an unstable ICU patient

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What are the critical care conditions or diagnoses?

How much time was spent managing this patient?

What did the author do in that time?

A better note: same unstable ICU patient

"Mr. Jones remains in critical condition requiring constant attention. While immediately available to the patient, I examined him and reviewed his recent events, ICU flow sheet data, laboratory analyses, and imaging studies. His current critical care problems include:

1) Severe respiratory failure. I have had to increase his inspired oxygen concentration (FIO2) to 80% to maintain his arterial oxygen (PaO2) above 60 while on positive end-expiratory pressure (PEEP) of 15. Clearly, he needs continuous mechanical ventilation to sustain life. His chest XRay shows diffuse bilateral infiltrates, consistent with Acute Respiratory Distress Syndrome (ARDS).

2) Coagulopathy with hemorrhage. I transfused him 4 units of packed red blood cells over the past 24 hours, along with fresh-frozen plasma & cryoprecipitate. Continuous assessment and supplementation is necessary to prevent uncontrolled hemorrhage and hypovolemia.

3) Hemodynamic instability. He requires continuous infusions of vasoactive agents (epinephrine and dobutamine) to maintain his systolic arterial blood pressure in the 90s. Otherwise, he would progress into circulatory shock, organ failures, and death.

4) Multiple electrolyte disturbances. Today's laboratory data reveal a low potassium of 3.3, a low ionized calcium of 1.08, and low magnesium of 1.5. We will administer supplements of these electrolytes in order to forestall further deterioration and circulatory disturbances.

The overall picture is that of overwhelming sepsis with septic shock, unresponsive to current broad-spectrum antibiotic management. He is a good candidate for Xygress, although his prognosis remains grim. I spent a total of 80 minutes in the critical care of this patient."

A better note: same unstable ICU patient

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Standard phrases like these can be automated.

A better note: same unstable ICU patient

"2) Coagulopathy with hemorrhage. I transfused him 4 units of packed red blood cells over the past 24 hours, along with fresh-frozen plasma & cryoprecipitate. Continuous assessment and supplementation is necessary to prevent uncontrolled hemorrhage and hypovolemia.

3) Hemodynamic instability. H… infusions of vasoactive agents (epine… maintain his systolic arterial blood pre… Otherwise, he would progress into circulatory shock, organ failures, and death.

These phrases justify critical care billing

4) Multiple electrolyte disturbances. Today's laboratory data reveal a low potassium of 3.3, a low ionized calcium of 1.08, and low magnesium of 1.5. We will administer supplements of these electrolytes in order to forestall further deterioration and circulatory disturbances."

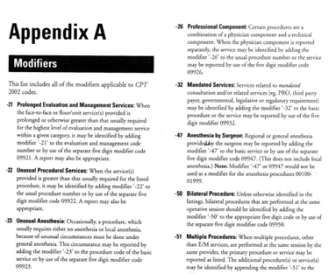
A better note: same unstable ICU patient

"The overall picture is that of overwhelming sepsis with septic shock, unresponsive to current broad-spectrum antibiotic management. He is a good candidate for Xygress, although his prognosis remains grim. I spent a total of 80 minutes in the critical care of this patient."

This note generates $246,60 from Medicare in Indiana in 2013 (possibly more after the DoctorFix)

Modifiers

- Modifiers are used to indicate that the basic assumptions about a charge have been changed
- The CPT system currently contains 34 modifiers.
  - 6 modifiers are applied to CPT codes for E&M Services
  - 27 modifiers are applied to procedural CPT codes
  - 1 can be applied to both
- Modifiers are listed in Appendix A of the CPT book



Appendix A

Modifiers

This list includes all of the modifiers applicable to *CPT 2002* codes.

-21 Prolonged Evaluation and Management Services: When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier '-21' to the evaluation and management code number or by use of the separate five digit modifier code 09921. A report may also be appropriate.

-22 Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '-22' to the usual procedure number or by use of the separate five digit modifier code 09922. A report may also be appropriate.

-23 Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier '-23' to the procedure code of the basic service or by use of the separate five digit modifier code 09923.

-26 Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '-26' to the usual procedure number or the service may be reported by use of the five digit modifier code 09926.

-32 Mandated Services: Services related to *mandated* consultation and/or related services (eg, PRO, third party payer, governmental, legislative or regulatory requirement) may be identified by adding the modifier '-32' to the basic procedure or the service may be reported by use of the five digit modifier 09932.

-47 Anesthesia by Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding the modifier '-47' to the basic service or by use of the separate five digit modifier code 09947. (This does not include local anesthesia.) **Note:** Modifier '-47' or 09947 would not be used as a modifier for the anesthesia procedures 00100-01999.

-50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding the modifier '-50' to the appropriate five digit code or by use of the separate five digit modifier code 09950.

-51 Multiple Procedures: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier '-51' to the

Modifiers should be applied when:

- the modifier adds more information regarding the anatomic site of the procedure;
- the modifier helps to eliminate the appearance of duplicate billing; or
- a modifier will help to eliminate the appearance of unbundling.

Global surgical package

- Global package = Surgical tradition
  - i.e., post-operative suture removal
- Defined services included in global surgical period: ***Routine postoperative care only***
- Different global periods for different procedures
  - 90 days
  - 10 days
  - 0 days
  - "YYY" – variability in global period can be determined by carrier
- RVU table published annually by CMS identifies how many "Global Days" associated with procedures

Modifiers indicate that global package does not apply in these circumstances

- Initial consultation or evaluation of the problem by the surgeon to determine the need for surgery
- Services of other physicians, typically dealing with other conditions
  - Collaborative care is separately billable, but not shared care
- Visits unrelated to the diagnosis for which the surgical procedure is performed
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery
- Diagnostic tests and procedures, including diagnostic radiological procedures
- Clearly distinct surgical procedures during the postoperative period which are not reoperations or treatment for complications

Modifiers indicate that global package does not apply in these circumstances

- Treatment for postoperative complications which requires a return trip to OR
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately
- For certain services performed in a physician's office, separate payment may be made for a surgical tray (code A4550). Also, splints and casting supplies are payable separately
- Immunosuppressive therapy for organ transplants
- Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician

Requirements for Billing During the Global Period: Modifiers

Period	Type of CPT Code Being Modified: Evaluation & Management	Procedure
Same day as global procedure	-25 (Unrelated; for 0- & 10-day globals) -57 (Decision for surgery; for 90-day globals)	-51 (Multiple) -59 (Distinct)
Post-procedure day global period	-24 (Unrelated)	-79 (Unrelated) -78 (Related) -58 (Staged)

Example of modifier use

- Coding & Billing for Initial Assessment + FAST exam in ED:
  - Initial H&P: CPT 99223 (High complexity)
    - 3.86 wRVUs
    - 5.81 total RVUs
  - FAST: CPT 76700 (Ultrasound, abdominal, real time with image documentation; complete)
    - 0.81 wRVUs
    - 4.23 total RVUs
  - Documentation:
    - Extensive H&P – necessary for head-to-toe initial assessment
    - Capture FAST image into chart
    - Bill 99223-25 and 76700
      - For almost all procedures, Medicare assumes any E&M work is bundled into the procedure's global payment
      - The -25 modifier indicates that assumption in invalid

Billing E and M codes vs critical care time in the ED

E&M Type		Complexity				
		Low	Low-Medium	Medium	Medium-High	High
Initial hospital care	Code	99221		99222		99223
	wRVUs	1.92		2.61		3.86
Outpatient consultation	Code	99241	99242	99243	99244	99245
	wRVUs	0.64	1.34	1.88	3.02	3.77
Emergency Department visit	Code	99281	99282	99283	99284	99285
	wRVUs	0.45	0.88	1.34	2.56	3.8
Critical care		1st hour	Additional ½ hours			
	Code	99291	99292			
	wRVUs	4.5	2.25			

Billing moderate sedation and procedures

- Moderate sedation codes: 99143-99150
  - Defined as a drug induced depression of consciousness. The patient maintains the ability to respond purposely to verbal direction or verbal direction either alone or accompanied by light tactile stimulation. Interventions are not required to maintain the patient's airway.
  - Included services:
    - Assessment of the patient
    - Establishment of IV access
    - Administration of agent(s)
    - Maintenance of sedation
    - Monitoring of oxygen saturation, heart rate, and blood pressure, and
    - Recovery

Billing moderate sedation while performing the procedure

- Moderate sedation codes:
  - 99143: 1st 30 minutes of moderate sedation provided by the same physician performing the procedure for patients <5 y/o
  - 99144: 1st 30 minutes of moderate sedation provided by the same physician performing the procedure for patients ≥5 y/o
  - 99145: Each additional 15 minutes.

Billing moderate sedation while someone else performs the procedure

- Moderate sedation codes:
  - 99148: 1st 30 minutes of moderate sedation provided by a physician other than the one performing the procedure for patients <5 y/o
  - 99149: 1st 30 minutes of moderate sedation provided by a physician other than the one performing the procedure for patients ≥5 y/o
  - 99150: Each additional 15 minutes.

Documenting moderate sedation

- The intraservice time should be documented in the ED chart.
  - Starts with the administration of the sedation agent(s),
  - Requires continuous face to face attendance
  - Ends at the conclusion of this personal contact by the physician
  - Assessment of the patient and recovery, once personal contact is concluded, are not included in intraservice time.

Bundled Conscious Sedation

- 321 procedure codes which include Moderate (Conscious) Sedation, therefore separate billing for MCS is not allowed.
  - Appendix G in CPT manual
  - Includes:
    - Bronchoscopies
    - Chest tubes
    - Pericardiocentesis
    - Pacemaker insertions
    - Central lines
    - Endoscopies
    - Percutaneous drainages
    - TEEs
    - PA (Swan-Ganz) catheter insertions
- Codes 99143-99145 (MCS performed by individual performing the procedure) should not be used with the procedures in appendix G

Moderate (Conscious) Sedation Payment

- Currently valued by Medicare as 0.00 RVUs
- Payments are carrier specific
- Payments range from $19 - $25 per 30 minutes
- Payments are higher for physician administering MCS and not performing the procedure
- Physicians performing the procedure are locked out of payment for many procedures due to bundling

How to bill the patient who arrives as a trauma alert, but goes home from the ED

- Options:
  - Outpatient consultation (99241-99245)
  - ED visit (99281-99285)
- No injuries = no diagnoses = no billable service?
  - Use V71.4 (Observation for trauma)
  - Also useful for overall trauma service management of patient with multiple injuries which are managed by other specialties

Billing with physician extenders

- Physician extenders can bill:
  - By themselves
    - 85% of Medicare Physician Fee Schedule (MPFS) payment
  - "Incident to" physician services
    - 100% of MPFS payment
    - Must be employed by physician (i.e., not by hospital)
    - Physician must perform the initial exam
    - Physician must directly supervise the physician extender
    - Usually applied for PEs working in physician's office when physician is present
    - Medicare does not pay physician for "incident to" services performed in the hospital
  - With physician in shared visits
- Different insurance companies may have different rules for physician extenders from Medicare's

Billing with physician extenders

- Shared visits
  - physician extender & physician from the same service who both perform face-to-face E&M services on the same day
  - combine their services as one E&M charge
  - Bill it under the physician's provider number
  - Reimbursed at 100% of 80% of the Physician Fee Schedule rate.
  - Example: NP rounds on patients in AM, then accompanies physician or physician rounds independently in PM
- Physician extender visits
  - only the extender conducts a fac e-to-face evaluation
  - bill must be submitted under the extender'sname and provider number
  - cannot be submitted under the physician's name and provider number
  - Medicare will pay the extender or extender's employer 85% of 80% of the Physician Fee Schedule rate.
  - Example: NP rounds on patients. Physician in the ED & OR all day and never rounds on service

Potential problems with physician extenders

- Extenders employed by hospital
  - Become competitors with self-employed physicians for RVUs
  - Only one billable visit per day by the service
  - Likely exception: Critical Care
    - Multiple providers from multiple specialty codes can perform critical care during the day
      - not simultaneously
      - General surgeon specialty code: 02
      - Critical care physician specialty code: 81
      - NP specialty code: 50
- Extenders employed by physician or same organization that employs physician
  - Collaborative relationship
  - Billing under physician's number depends upon level of physician involvement

Summary

- Specific requirements detail what is necessary to bill critical care in the global period. ***ALL ARE ACHIEVABLE***
- Billing for moderate sedation is often a long run for a short slide
- If the patient meets criteria for critical care services, bill it instead of other E&M codes
- The non-injured patient carries the diagnosis code of V71.4 in order to get paid for your E&M services
- Physician extenders can be a huge benefit if your program is structured properly

Hernia Surgery

Hernia Classifications

According to the symptoms they present, there are three general types of hernias: reducible, incarcerated, and strangulated.

What is a Reducible Hernia?

A reducible hernia (free mobility of the hernia through the hernia orifice) is one that can be corrected by manipulation.

What is an Incarcerated Hernia?

An incarcerated hernia is one where there is "abnormal imprisonment of a part (i.e., a hernia that is nonreducible)".

- A hernia may become non reducible secondary to incarceration, adhesion formation, and/or size of the hernia.
- A nonreducible hernia is one that cannot be reduced by manipulation. In these types of hernias, the hernial contents are fixed in the hernial sac.
- Strangulation is the most serious complication related to a hernia.
- Congestion or strangulation at the hernial ring impairs the blood supply to the herniated part. Once the vessels are obstructed, a simple incarceration becomes a strangulation.

Hernia Repairs: Hernioplasty, Herniorrhaphy, Herniotomy

Hernia CPT codes are classified in the CPT manual by:

- The type of hernia (e.g., inguinal, femoral, incisional)
- "Initial" or "recurrent" based on whether or not the hernia has required previous repair(s)
- Patient age
- Reducible vs. incarcerated or strangulated
- Open versus laparoscopic
- With or without mesh (only reported with CPT code ranges 49560-49566)

Other Services to Consider (refer to CPT Manual for full instructions)

- The excision/repair of strangulated organs or structures such as testicle(s), intestine, ovaries are reported by using the appropriate code for the excision/repair (e.g., 44120, 54520, and 58940) in addition to the appropriate code for the repair of the strangulated hernia.
- Refer to 11042, 11043 for debridement of abdominal wall (non-necrotizing fascia, 11005).
- Report +11008 for removal of prosthetic material or mesh, abdominal wall, for infection. 11008 is an add-on code and may be reported with 10180, 11004-11006.
- Use 49568 in conjunction with 11004-11006, 49560-49566.
- Hydrocelectomy (55040) may be reported with a hernia repair described by CPT codes (49505-49507).
- Incisional, ventral, and umbilical hernia repair is included in other more extensive surgery except as noted.

Hernioplasty, Herniorrhaphy, Herniotomy

CPT Code	Description	Comments	Global Days	F RVUs
49491	Repair, initial inguinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; reducible		90	23.49
49492	incarcerated or strangulated	➢ Do not report modifier 63 in conjunction with 49491, 49492 ➢ Postconception age equals gestational age at birth plus age of infant in weeks at the time of the hernia repair. Initial inguinal hernia repairs that are performed on preterm infants who are older than 50 weeks postconception age and younger than age 6 months at the time of surgery, should be reported using codes 49495, 49496	90	27.53
49495	Repair, initial inguinal hernia, full term infant under age 6 months, or preterm infant over 50 weeks postconception age and under age 6 months at the time of surgery, with or without hydrocelectomy; reducible		90	11.68
49496	incarcerated or strangulated	➢ Do not report modifier 63 in conjunction with 49495, 49496 ➢ Postconception age equals gestational age at birth plus age in weeks at the time of the hernia repair. Initial inguinal hernia repairs that are performed on preterm infants who are younger than or up to 50 weeks postconception age but younger than 6 months of age since birth, should be reported using codes 49491, 49492. Inguinal hernia repairs on infants age 6 months to younger than 5 years should be reported using codes 49500-49501	90	16.93
49500	Repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; reducible		90	11.15
49501	incarcerated or strangulated		90	17.94

2013 RVUs

Hernioplasty, Herniorrhaphy, Herniotomy

CPT Code	Description	Comments	Global Days	F RVUs
49505	Repair initial inguinal hernia, age 5 years or over; reducible		90	15.45
49507	incarcerated or strangulated	➢ See 49505 or 49507 and 54520 for inguinal hernia repair, with simple orchiectomy ➢ See 49505 or 49507 and 54840 or 55040 for inguinal hernia repair, with excision of hydrocele or spermatocele, see 49505 or 49507 and 54840 or 55040	90	17.37
49520	Repair recurrent inguinal hernia, any age; reducible	➢ Do not report 49568 or 15777	90	18.70
49521	incarcerated or strangulated		90	21.17
49525	Repair inguinal hernia, sliding, any age	➢ See 49496, 49501, 49507, 49521 for incarcerated or strangulated inguinal hernia repair	90	16.97
49540	Repair lumbar hernia		90	20.01
49550	Repair initial femoral hernia, any age; reducible		90	17.08
49533	incarcerated or strangulated		90	18.70
49555	Repair recurrent femoral hernia; reducible		90	17.68
49557	incarcerated or strangulated		90	21.36
49560	Repair initial incisional or ventral hernia; reducible	➢ Report 49568 as appropriate	90	21.79
49561	incarcerated or strangulated	➢ Report 49568 as appropriate	90	27.46
49565	Repair recurrent incisional or ventral hernia; reducible	➢ Report 49568 as appropriate	90	22.71
49566	incarcerated or strangulated	➢ Report 49568 as appropriate	90	27.75
+49568	Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)	➢ Report 49568 as appropriate	ZZZ	7.84
49570	Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)		90	12.43
49572	incarcerated or strangulated		90	15.31
49580	Repair umbilical hernia, under age 5 years; reducible		90	9.97
49582	incarcerated or strangulated		90	14.36
49585	Repair umbilical hernia, age 5		90	13.31

Hernioplasty, Herniorrhaphy, Herniotomy

CPT Code	Description	Comments	Global Days	F RVUs
	years or over; reducible			
49587	incarcerated or strangulated		90	14.15
49590	Repair spigelian hernia		90	16.98
49600	Repair of small omphalocele, with primary closure	➢ Do not report modifier 63 in conjunction with 49605, 49606	90	21.61
49610	Repair of omphalocele (Gross type operation); first stage		90	144.82
49611	second stage	➢ Do not report modifier 63 in conjunction with 49610, 49611) ➢ See 39503, 43332 for diaphragmatic or hiatal hernia repair ➢ Use 49999 for surgical repair of omentum	90	33.36

2013 RVUs

Laparoscopic Hernia Repairs (49650 – 49659)

CPT Code	Description	Comments	F RVUs
49650	Laparoscopy, surgical; repair initial inguinal hernia		12.73
49651	recurrent, inguinal hernia		16.57
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible	➢ Do not report 49652 in conjunction with 44180, 49568	20.35
49653	incarcerated or strangulated	➢ Do not report 49653 in conjunction with 44180, 44568	25.37
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible		23.07
49655	incarcerated or strangulated	➢ Do not report 49655 in conjunction with 44180, 49568	28.15
49656	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible	➢ Do not report 49656 in conjunction with 44180, 49568	25.01
49657	incarcerated or strangulated	➢ Do not report 49657 in conjunction with 44180, 49568	35.88
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy		0

2013 RVUs

Coding for Complex Ventral or Incisional Hernia Repairs with Component Separation Release

Component Separation of the Abdominal Wall

- Oblique muscles or transversalis muscles are incised lateral to the hernia and the rectus muscles are mobilized toward the midline.

Muscle Flap Reconstruction

CPT Code	Descriptor	2013 RVUs	Global Days
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk	39.41	90

2013 RVUs

Hernia Codes

CPT Code	Descriptor	2013 RVUs	Global Days
49560	Repair initial incisional or ventral hernia; reducible	21.79	90
49561	incarcerated or strangulated	27.46	90
49565	Repair recurrent incisional or ventral hernia; reducible	22.71	90
49566	incarcerated or strangulated	27.75	90

2013 RVUs

Mesh/Biologic

CPT Code	Descriptor	2013 RVUs	Global Days
+ 49568	Implantation of **mesh or other prosthesis** for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)	7.84	ZZZ

2013 RVUs

Coding Tips

- Document type of hernia repair and choose code based on initial or recurrent, reducible or strangulated or incarcerated.
- Report 49568 for mesh or placement of skin substitutes which meet the definition of mesh in this case as an "other prosthetic."
- **DO NOT REPORT** 15777 for mesh implant.
- CPT code 15734 may be reported twice for the bilateral mobilization of the rectus muscle. According to Medicare, the bilateral procedure concept does not apply, thus append modifier 59 to indicate distinct separate procedure.
- Note the muscle flap has the highest RVU, thus will be listed as the primary procedure.
- **DO NOT report** codes for complex closure as an additional procedure for closure of the wound. Closure is included in the hernia repair and flap codes.

CPT and Medicare Surgical Package Definitions

CPT Guidelines

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 are always included in addition to the operation per se:

- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure ***(including history and physical)***
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
- Writing orders
- Evaluating the patient in the post-anesthesia recovery area
- Typical postoperative follow-up care (Medicare says 0, 10 or 90 days postop)

What CPT Says About Pre-Op Visits

Question:

Are preoperative visits billable? If so, what code should be used and what is the time frame before surgery to submit this code?

Visits for the intent of pre-op H&P questions, consents are not reportable.

Answer:

If the decision for surgery occurs the day of or before the major procedure and includes the preoperative evaluation and management (E/M) services, then this visit is separately reportable. Modifier 57, Decision for Surgery, is appended to the E/M code to indicate this is the decision-making service, not the history and physical (H&P) alone. If the surgeon sees the patient and makes a decision for surgery and then the patient returns for a visit where the intent of the visit is the preoperative H&P, and this service occurs in the interval between the decision-making visit and the day of surgery, regardless of when the visit occurs (1 day, 3 days or 2 weeks) the visit is not separately billable as it is included in the surgical package. Example: The surgeon sees the patient on March 1 and makes a decision for surgery. Surgery is scheduled for April 1. The patient returns to the office on March 27 for the H&P, consent signing, and to ask and clarify additional questions. The visit on March 27 is not billable, as it is the preoperative H&P visit and is included in the surgical package.

Source: AMA CPT Assistant, May 2008/Volume 19, Issue 5, pp. 9, 11

What's Not Included in the Surgical CPT Package

Follow Up Care for Diagnostic Procedures: F/up care for diagnostic procedures includes only that care related to recovery from the diagnostic procedure. Care of the condition for with the diagnostic procedure was performed or of other concomitant conditions is not included and may be reported separately.

Follow Up Care for Therapeutic Surgical Procedures: F/up care for therapeutic surgical procedures includes only that care which is usually a part of the surgical service. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services should be separately reported (CPT vs Medicare).

Medicare Surgical Package and Medicare Payment on Global Surgical Payment Allocation

Medicare Guidelines:

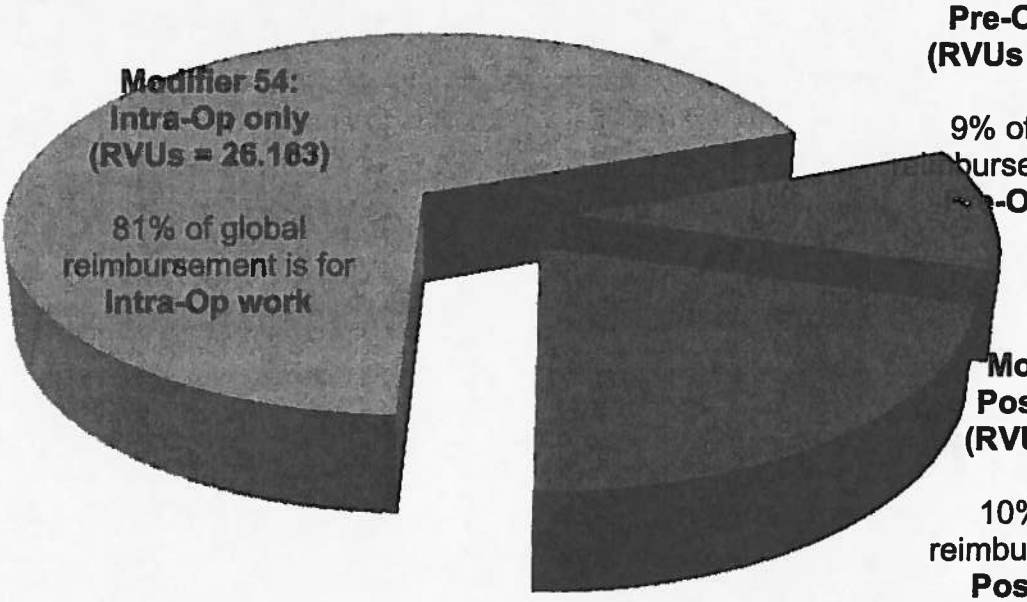
The Medicare approved amount for these procedures includes payment for the following services related to the surgery when furnished by the physician who performs the surgery. The services included in the global surgical package may be furnished in any setting, e.g., in hospitals, ASCs, physicians' offices. Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon. However, critical care services (99291 and 99292) are payable separately in some situations.

- **Preoperative Visits** - Preoperative visits after the decision for surgery is made to operate.
- **Intra-operative Services** - Intra-operative services that are normally a usual and necessary part of a surgical procedure;
- **Complications Following Surgery** - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;
- **Postoperative Visits** - Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;
- **Postsurgical Pain Management** - By the surgeon;
- **Supplies** - Except for those identified as exclusions; and
- **Miscellaneous Services** - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters.

44005: Enterolysis (freeing of intestinal adhesion) (separate procedure)

	Facility RVUs		
44005	**Work RVU**	**Practice Exp**	**Malpractice**
2013	18.46	10.00	3.84

CPT Code 44005 = 32.30 RVUs 2013



Modifiers: What Are They?

2013 Revisions

What are they?
A modifier is a two digit code appended to a CPT code to indicate that a service or procedure has been altered by some specific circumstance, but not changed in its definition or code. An exception to the two digit code is the anesthesia modifiers and the use of HCPCS modifiers for toes and fingers.

When would you use a modifier?
There are many conditions when it may be appropriate for a provider to append a modifier to indicate a special circumstance when reporting a service.

These may include, but are not limited to:
- Report a multiple procedure (51), bilateral procedure (50), or distinct procedure (59)
- Report the work of an Assistant Surgeon (80, 81, 82) or Two Surgeon (62) involvement on a surgical case
- Report the professional component of a service (26)

On what types of codes are modifiers appended?
- E&M services (24, 25, 57)
- Surgical procedures
- Radiology and Diagnostic Nerve Studies (26 & TC)
- Services from the Medicine Section

Can more than one modifier be appended to a procedure or service?
- Yes, always list the most specific modifier first (closest to the CPT code)

Who should append the modifiers?
- The provider of the service knows best if a special circumstance exists.
- Coding staff should be the second set of eyes to ensure the appropriate modifier is linked to the CPT codes.

Note: The major revision to the modifiers in 2013 is the addition of the term "other qualified health care professional."

2013 Modifier Revisions

CPT Level I Modifiers

24 Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period:
The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

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:
It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Service Guidelines for instruction on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M service. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M service, see modifier 59.

26 Professional Component:
Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

51 Multiple Procedures:
When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).

52 Reduced Services:
Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

53 Discontinued Procedure:
Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure.

Note: *This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.*

58 Staged of Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period:
It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: For treatment of a problem that requires a return to the operating/procedure room (e.g., unanticipated clinical condition), see modifier 78).

62 Two Surgeons:
When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. ***Note:*** *If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.*

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional:
It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional: *It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.*

78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period:
It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76).

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period:
The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76).

Operative Note Dictation Tips for Coding and Appeals

Preoperative Diagnosis
Postoperative Diagnosis

- Differentiate when possible.
- Note known tumor pathology post-op.
- Use ICD-9 terminology.
- Report underlying co-morbid conditions that can affect a surgical outcome.

Surgeon

Primary Surgeon for the case
- Dictate op notes and role of assistants

Assistant Surgeon (80, 81, 82)

- Assists in the primary procedure as a "skilled extra pair of hands"
- Has no pre-op responsibility
- Does not dictate an op note
- Not primarily responsible for post-op care
- Role is dictated in op note by primary surgeon
- Use "AS" for PA, NP, CNS billing to Medicare

Co-Surgeon (62)

- Usually has pre-op responsibilities
- Always dictates a separate op note for his/her part of the procedure
- Usually has some post-op responsibility
- Brings different expertise to the table

Procedure

List procedures performed. Use CPT terminology as much as possible.

Indications for Surgery

Patient age, previous related surgery, why patient brought to OR, planned future surgery. Give indication or reason why certain modifiers may be used.

Findings at Surgery

A **must** for modifier 22.

Details

The "body" of the report generally read only by other surgeons. Documentation provides detail of procedures.

TIP

Create an operative report that would stand alone in an appeal situation – avoid having to dictate separate letters of justification. The op note should provide all necessary documentation.

Unlisted Procedures: A Bit of a Gamble

Unlisted Procedures: Coding Tips:

- Use when there is no CPT code to describe the surgical procedure assuming a modifier 22 or 52 is not appropriate.
- Obtain written prior authorization for elective cases.
- Determine if payor will allow 1) a paper claim and operative note to be sent 2) allow an electronic claim form and electronic submission (secured e-file, fax) of operative note at same time as claim submission.
- Do not use if a code exists for the procedure because you do not like the payment amounts.
- Do not add modifiers to unlisted codes.
- Do not report more than one unlisted code per anatomic area per operative session.

Setting Fees for Unlisted Procedures
If no CPT code exists for the procedure, report an unlisted code and follow these steps for fee setting and writing a cover letter to submit with the claim:

1. Choose a code *similar* to the unlisted procedure you performed. This will be your "base code." Keep in mind that code should represent surgery on the same body area; use the same or similar approach and exposure.
2. List 2-3 things that make the unlisted procedure more or less difficult than the existing comparison code in CPT.
3. Assess the RVUs of the similar code making sure you feel it represents a "fair value" for the work involved. If it does not, continue looking.
4. Convert this greater or lesser degree of difficulty to a % increase or decrease in your fee for the existing comparison code.
5. List your normal fee for the existing comparison code. Keep in mind that the % is critically important. The payor will adjust up or down from their fee schedule, not your charge.
6. Do not attempt to un-bundle (list separately) procedures that are conventionally included in a global surgery (i.e., ultrasound guidance)

Protecting E&M Services from the Global Surgical Package

Protecting E&M Services from the Global Surgical Package

CPT and Medicare

The following services are included when you report a major procedure:

- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia.
- Subsequent to the decision for surgery, one related Evaluation and Management (E&M) encounter on the date immediately prior to or on the date of procedure (including history and physical).
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians.
- Writing orders.
- Evaluating the patient in the post anesthesia recovery area.

Modifier 57: Decision for Surgery

- An evaluation and management service resulting in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E&M service. This modifier is only necessary if the E&M is performed on same day or day before major (90 day) global procedure.
- Typically used to indicate an urgent decision to operate and not for planned surgical events.

CPT	Medicare
Same	Same
Example: On 1/1/2013 patient presents to the ER with RUQ pain. Patient is taken to the OR for a laparoscopic cholecystectomy. **Report: 992xx-57 and 47562** to indicate the urgent decision to operate and not the H&P for a planned surgical procedure.	

Modifier 25: Significant, Separately Identifiable Evaluation And Management Service By The Same Physician or Other Qualified Healthcare Professional On The Same Day Of The Procedure Or Other Service

- Used to report a significant, separately identifiable evaluation and management service by same physician on the day of a procedure. The E&M service may be prompted by the symptom or condition for which the procedure and/or service was provided.
- As such, different diagnoses are not required for reporting of the E&M services on the same date.
- Typically appended to E&M services on same day as a minor procedure "0" or "10" day global.

CPT	Medicare
Same	Some Medicare carriers do not want modifier 25 appended on new patient visits.
Example: A new patient presents for evaluation of breast cyst. The surgeon evaluates and decides to perform an aspiration. **Report 9920x-25** and **19100** (aspiration cyst of breast). Modifier 25 indicates the E&M was the significant service and the decision for the cyst aspiration was based on the E&M service.	

Protecting E&M Services from the Global Surgical Package

(Modifier 25 continued)

- Remember, to report an E&M with a minor surgical procedure the E&M must be the "significant, separate" service. If not, both the E&M and the surgical procedure are not separately reportable.

Example #1: Same problem, repeat procedure
Patient returns for repeat evaluation three weeks later, as the cyst has returned. Following evaluation of the patient, the surgeon determines there have been no significant changes in the history or exam and re-aspirates the cyst.

The surgeon reports:

CPT	Medicare
Same	Same
19100 – Aspiration, breast cyst only	19100 – Aspiration, breast cyst only

Example #2: Separate problems

Example: Patient returns in follow-up for the cyst and also asks the surgeon to evaluate a new lesion on her chest. The physician evaluates the lesion and performs a follow-up aspiration.

CPT		Medicare	
Same		Same	
9921X-25	Skin Lesion Diagnosis	9921X-25	Skin Lesion Diagnosis
19100	Breast Cyst Diagnosis	19100	Breast Cyst Diagnosis

Modifiers & the Global Surgical Package

ASOA

April 2012

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CMS References

Global Surgery Fact Sheet:
https://www.cms.gov/MLNProducts/downloads/GloballSurgery-ICN907166.pdf

Medicare Claims Processing Manual:
http://www.cms.gov/manuals/downloads/clm104c12.pdf

Definition of a Global Surgical Package

- Medicare established a national definition of a global surgical package to ensure that payment is made consistently for the same service across all Medicare contractor (Carriers and Medicare Administrative Contractors (MACs)) jurisdictions
- This policy helps prevent Medicare payments for services that are more or less comprehensive than intended. In addition to the global policy, uniform payment policies and claims processing requirements have been established for other surgical issues, including bilateral and multiple surgeries, co-surgeons, and team surgeries.

Definition of a Global Surgical Package

- The global surgical package, also called global surgery, includes all necessary services normally furnished by a surgeon before, during, and after a procedure.
- Medicare payment for the surgical procedure includes the pre-operative, intra-operative and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty.
- Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.

M/C Global Surgical Package

- Global Surgical Concept Developed in 1992
  - One global fee created to include all portions of service
- Preoperative Visits.--Preoperative visits after the decision is made to operate. For major procedures, this includes pre-operative visits the day before the day of surgery. For minor procedures, this includes pre-operative visits the day of surgery;
- When concept created pre-op was typically performed the day before the surgical procedure
  - Medicare does not want to make additional payment for office visits following the decision for surgery
  - If patient seen for preoperative visit should not be billed as medically necessary regardless of date of service

M/C Global Surgical Package

- Intraoperative services that are normally a usual and necessary part of a surgical procedure;
- All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;
- Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery;
- Post-surgical pain management by the surgeon;
- Supplies, except for those identified as exclusions; and

M/C Global Surgical Package

- Miscellaneous services, such as dressing changes, local incision care, removal of operative pack, **removal of cutaneous sutures and staples, lines, wires, tubes**, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

- Outside of the post-op period the above removals are not billed separately from the level of office visit rendered on the same day

M/C Global – Not Included

- Initial consultation or evaluation of the problem by the surgeon to determine the need for major surgeries. This is billed separately using the modifier -57 (Decision for Surgery). This visit may be billed separately only for major surgical procedures;
- Services of other physicians related to the surgery, except where the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record;

M/C Global – Not Included

- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery;
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery;
- Diagnostic tests and procedures, including diagnostic radiological procedures;

M/C Global – Not Included

- Clearly distinct surgical procedures that occur during the post-operative period which are not re-operations or treatment for complications;
- **Note:** A new post-operative period begins with the subsequent procedure. This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure.

M/C Global – Not Included

- Treatment for post-operative complications requiring a return trip to the Operating Room (OR). An OR, for this purpose, is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures.
- The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR);

M/C Global – Not Included

- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately;
- Immunosuppressive therapy for organ transplants; and
- Critical care services (Current Procedural Terminology (CPT) codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

Global Surgery Classifications

Zero Day Post-operative Period (endoscopies and some minor procedures),

- No pre-operative days
- No post-operative days
- Visit on the day of procedure is generally not payable as a separate service
- For ophthalmology this includes injections, such as 67028 and lash epilation by forceps

Global Surgery Classifications

10-day Post-operative Period, (other minor procedures).

- No pre-operative period
- Visit on the day of the procedure is generally not payable as a separate service
- Total global period is 11 days. Count the day of the surgery and 10 days following the day of surgery
- For ophthalmology this includes punctal plug placement, dilation and trabeculoplasty

Global Surgery Classifications

90-day Post-operative Period (major procedures)

- One day pre-operative included
- Day of the procedure is generally not payable as a separate service
- Total global period is 92 days. Count 1 day before the day of the surgery, the day of surgery, and the 90 days immediately following the day of surgery
- For ophthalmology this includes most procedures performed in an ASC setting

Major Surgical Packages

- Major Surgery
  - 90 Day Postoperative Period
- Major surgery package:
  - 1 preoperative visit, pre-op period starts the day before surgery
    - 10% of M/C Fee Schedule
  - 90 days of follow-up starting the day after surgery
    - 20% of M/C Fee Schedule
  - Surgical procedure
    - 70% of M/C Fee Schedule
  - Remember that global period is assigned to the billing group number
    - Other physicians in the group will need to use modifiers for unrelated services even if different specialty and different diagnosis

Minor Surgical Packages

- Minor Surgery = 0 or10 Days Post-Op
- Minor surgical package:
  - Includes 0-10 days of Post-op care
  - Procedure
  - Post-op visits for managing operative site
  - Does not include separate, identifiable visit or consult or follow-up of management for underlying disease

Modifier 24

- "Unrelated E/M Service by the Same Physician During a Postoperative Period"
- For office visit services only
- Applies to both E&M and eye codes
- Not applicable to tests in postoperative period – tests not included and paid separately
- Requires different diagnosis from surgery or eye modifier that is different from surgical eye.
- Many carriers have a system edit in place to deny claims billed with -24 for lack of medical necessity

Modifier 24

- May need to send additional documentation to get paid
  - May have to use comment area/Box 19 to indicate that documents are being faxed
    - List number of pages
  - Use local carrier fax cover sheet to send information to have it matched up with claim
  - Carrier will want progress note/office visit documentation for unrelated date of service

Modifier 25

Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service:

- It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

Modifier 25

- A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service.)
- The E/M service may be prompted by the symptom or condition for which the procedure and/or other service was provided. ***As such, different diagnoses are not required for reporting of the E/M services on the same date.*** This circumstance by be reported by adding modifier -25 to the appropriate level of E/M service. Note:
- This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

Modifier 25

- For office visit services only
- Visit will be denied on same day as minor procedure if billed without -25
  - Will be considered pre/post operative in nature and included
- Imperative to document the office visit as its own service, history, examination, impression and plan
- Document the minor procedure separately: List type of procedure, location, diagnosis, instrumentation, medication and outcome
- The diagnosis may be the same for both the E/M and the surgery or procedure
- Can try to use with other payers to break out payment for office visits and testing services on the same day
  - Remember to apply to visit code, not testing code

Modifier 57

- Decision for Major Surgery
  - Use when surgery is performed either the day of or the day after the INITIAL decision for surgery was made.
  - Emergent surgeries, lasers
  - Not for pre-operative visit
  - Append to visit/consultation code

Modifier 50

- Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding the modifier -50.
- Append when the same CPT-4 code is performed on both eyes (sides of the body)
- When billing Medicare submit one line, payment for surgical procedures will be approved at 150%, unilateral testing procedures at 200%
- Other insurance companies use two lines
- Do not apply reductions – Let insurance co. price

Modifier 51

- **Multiple Procedures:** When multiple procedures, other than E/M services, physical medicine and rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).
- Note: This modifier should not be appended to designated add-on codes (see Appendix D).

Modifier 51

- Payment for the primary surgical procedure will be approved at 100%
- Procedures 2-4 at 50% (Medicare)
- Additional procedures are by review

Modifier -53

- **Discontinued Services:** Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure.

Modifier -53

- Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled s a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

Modifier -53

- If a code exists for the portion of the procedure that was performed, use the code
- If no code exists, then append modifier -53 to the intended procedure

Modifier 58

- **Staged or Related Procedure or Service by the Same Physician During the Postoperative Period:** It may be necessary to indicate that the performance of a procedure or service during the postoperative period was (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure.
- Note: For treatment of a problem that requires a return to the operating or procedure room (eg, unanticipated clinical condition), see modifier 78.

Modifier 58

- -58 is appended to the second (or more) procedure(s) performed.
- No reduction in the fee schedule amount, full Global Surgical Package applies.
- Post-operative days restart
- CMS determined that the -58 modifier **does not** negate the global fee concept and therefore **does not** apply to the codes with "one or more session" language

Modifier -58

- (a) planned or anticipated (staged);
- (b) more extensive than the original procedure; or
- (c) for therapy following a surgical procedure

Modifier 78

- **Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period:** It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first and requires the use of an operating or procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see 76.)

Modifier 78

- Return to the operating room for a related procedure during a postoperative period
- An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. ...cardiac cath. suite, a laser suite, and an endoscopy suite.
- Does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit
- 20% reduction of fee schedule

Modifier 79

- Unrelated procedure by the same physician during a postoperative period
- The physician may need to indicate that the performance of a procedure or service during a postoperative period was unrelated to the original procedure.
- Post-operative days restart, no reduction in fee schedule

NCCI

- National Correct Coding Initiative
- First published in January 1, 1996, Updated Quarterly
- Code bundles of services that are not ordinarily performed and/or billed on the same day
- Created to prevent "unbundling" of services
- Bundles only apply to services when performed in the same session on the same day
- -59 or -25 modifiers can be used to "unbundle" services listed with a "1" footnote
- "0" footnote = service can never be unbundled
- "9" footnote = code bundle removed

NCCI

- Comprehensive/Component
- Mutually Exclusive
- Downloadable from: http://www.cms.hhs.gov/NationalCorrectCodInitEd/
  - Physician edits:
  - http://www.cms.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage

Comprehensive/Component

Association (or such other date of publication of CPT). All Rights

Column1/Column 2 Edits

Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable
67108	36000		20021001	*	1
67108	36410		20021001	*	1
67108	37202		20021001	*	1
67108	62318		20021001	*	1
67108	62319		20021001	*	1
67108	64415		20021001	*	1
67108	64416		20030101	*	1
67108	64417		20021001	*	1
67108	64450		20021001	*	1
67108	64470		20021001	*	1
67108	64475		20021001	*	1
67108	66840		19980101	*	1
67108	66850		19980101	*	1
67108	66852		19980101	*	1
67108	67015	*	19960101	*	1
67108	67025	*	19960101	*	1
67108	67028	*	19960101	*	1
67108	67031	*	19960101	*	1
67108	67036	*	19960101	*	1
67108	67038		20000905	20000905	9

Mutually Exclusive

67039	67038		19960101	19960101	9
67039	67040		19960101	*	1
67040	67038		19960101	19960101	9
67101	67105	*	19960101	*	1
67101	67107	*	19960101	*	1
67110	67107		19960101	*	1
67110	67108		19960101	*	1
67112	67108		19960101	*	1
67120	65175		19960101	*	1
67120	65260		19960101	*	1
67120	65265		19960101	*	1
67121	65260		19960101	*	1
67121	65265		19960101	*	1
67141	67145	*	19960101	*	1
67208	67210	*	19960101	*	1
67210	67220		20000605	*	1
67210	67221		20020401	*	1
67210	67228	*	19960101	*	1
67225	67210		20020401	*	1
67227	67228	*	19960101	*	1
67228	67220		20000605	*	1
67228	67221		20020401	*	1
67228	67225		20020401	*	1

Modifier 59

- **Distinct Procedural Service:** 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 or 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 or 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.

Modifier 59

- 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. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

Medicare Clarification

- One of the misuses of modifier –59 is related to the portion of the definition of modifier -59 allowing its use to describe "different procedure or surgery". The code descriptors of the two codes of a code pair edit usually represent different procedures or surgeries. The edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter.
- The provider cannot use modifier –59 for such an edit based on the two codes being different procedures/surgeries.

Medicare Clarification

- However, if the two procedures/surgeries are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier –59 may be appended to indicate that they are different procedures/surgeries on that date of service.
- Use of modifier -59 to indicate different procedures/surgeries does not require a different diagnosis for each HCPCS/CPT coded procedure/surgery.
- Additionally, different diagnoses are not adequate criteria for use of modifier -59. The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters.

Modifiers -22 & -52

- Unusual Circumstances.--Surgeries for which services performed are significantly greater than usually required may be billed with the "-22" modifier added to the CPT-4 code for the procedure. Surgeries for which services performed are significantly less than usually required may be billed with the "-52" modifier.

Modifier 22

- **Increased Procedural Services:** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required.)
- Note: This modifier should not be appended to an E/M service.

Modifiers -22 & -52

- Instruct billers to provide:
  - A concise statement about how the service differs from the usual; and
  - An operative report with the claim.
- Modifier "-22" should only be reported with procedure codes that have a global period of 0, 10, or 90 days. There is no such restriction on the use of modifier "-52."

Carrier Manual Instructions

- Forward all claims for surgeries billed with a "-22" or "-52" modifier, which include the statement and documentation required by §4822.A.10, to the medical review staff for review and pricing. If the statement and documentation are not submitted with the claim, price it as you would for the same surgery submitted without the "-22" modifier. Do not send these claims to the medical review staff.

Modifier -52 Case Study

- -52 Modifier is used to represent when less than a typical service is provided.
- Most typically for ophthalmology use -52 to report when a bilateral testing service is only performed on one eye.
- -52 is informational, payment is not reduced by the carrier and you are not required to reduce the fee submitted.
- If fee is reduced the carrier will approve the claim at 100% of the amount billed or the fee schedule, whichever is lower.

Q&A

Informational Modifiers

- Eyelids
  - E1 Upper left, eyelid
  - E2 Lower left, eyelid
  - E3 Upper right, eyelid
  - E4 Lower right, eyelid

- Body Sides
  - RT Right
  - LT Left

Central Venous Access

Central Venous Access Procedures

Central Venous Access Procedures

"To qualify as a central venous access catheter or device, the tip of the catheter/device must terminate in the subclavian, brachiocephalic (innominate) or iliac veins, the superior or inferior vena cava, or the right atrium".

The venous access device may be:

- Inserted **Centrally:** Inserted into the jugular, subclavian, femoral vein or inferior vena cava catheter entry site

OR

- Inserted **Peripherally:** For example, through the basilic or cephalic vein
- **The two most commonly inserted sites are the jugular and subclavian**

The Device May be Accessed:

- Through exposed catheter (catheter is external to the skin)
- Through a subcutaneous port
- Through a subcutaneous pump

Central Venous Access Procedures

Five Categories Define Central Venous Access Procedures

There is no coding distinction between venous access achieved percutaneously by cutdown or by catheter size.

- **Insertion:** Catheter placement through a newly established venous access site.
- **Repair:** Repair (fixing) of a device without replacement of either the catheter or port/pump, other than for pharmacologic or mechanical correction of intracatheter or pericatheter occlusion (See codes 35695 and 35696.)
- **Partial replacement** of only the catheter component associated with a port/pump device, but not entire device
- **Complete replacement** of entire device via same venous access site (complete exchange)
- **Removal** of entire device.

General Coding Principles:

- For the repair, partial (catheter only) replacement, complete replacement, or removal of both catheters *(placed from separate venous access sites)* of a multi-catheter device, with or without subcutaneous ports/pumps, report the appropriate CPT code describing the service with a frequency of two.
- If the physician removes an existing central venous device (report removal if code exists) and replaces device through a separate venous access site, both removal and new device may be reported.
- Report CPT codes 76937 or 77001 when using imaging to either gain access to the venous site or to manipulate the catheter into final position.

Central Venous Access Procedures

Device Insertion Codes: Central Insertion, Tunneled vs Non Tunneled

Insertion of Centrally Inserted Venous Catheter Without Pump			
CPT Code	**Tunneled vs. Non-tunneled**	**Central vs. Peripheral Insertion**	**Over/Under Age 5**
⊙36555	Non-tunneled	Central	Under
36556	Non-tunneled	Central	Over
⊙36557	Tunneled	Central	Under
⊙36558	Tunneled	Central	Over

Medicare Payment Information:

CPT[1]	Physician Work RVUs	Total RVUs Non-Facility	Total RVUs Facility	Global Days
⊙36555	2.68	7.63	3.42	000
36556	2.50	7.05	3.56	000
⊙36557	5.14	23.85	9.16	010
⊙36558	4.84	24.17	8.33	010

2013 RVUs

Device Insertion Codes: Central Insertion, Tunneled with or Without Port or Pump

Insertion of Tunneled Centrally Inserted Venous Catheter With or Without Port or Pump					
CPT Code	**Tunneled vs. Non-tunneled**	**Central vs. Peripheral Insertion**	**Over/Under Age 5**	**With or Without Port or Pump**	**Other**
⊙36560	Tunneled	Centrally	Under	With subcutaneous port	
⊙36561	Tunneled	Centrally	Over	With subcutaneous port	
⊙36563	Tunneled	Centrally	NA	With subcutaneous pump	
⊙36565	Tunneled	Centrally	NA	Without pump or port (e.g. Tesio type catheters)	Requires two catheters via two separate access sites
⊙36566	Tunneled	Centrally	NA	With subcutaneous port(s)	Requires two catheters via two separate access sites

Medicare Payment Information:

CPT[1]	Physician Work RVUs	Total RVUs Non-Facility	Total RVUs Facility	Global Days
⊙36560	6.29	42.45	10.91	010
⊙36561	6.04	36.9	10.66	010
⊙36563	6.24	41.9	11.38	010
⊙36565	6.04	31.04	10.54	010
⊙36566	6.54	173.25	11.5	010

2013 RVUs

Central Venous Access Procedures

Device Insertion Codes: Peripheral Insertion, Tunneled with or Without Port or Pump

Insertion of Peripherally Inserted Venous Catheter With or Without Port or Pump			
CPT Code	**Central vs. Peripheral Insertion**	**Over/Under Age 5**	**With or Without Port or Pump**
⊙36568	Peripheral (PICC)	Under	Without port or pump
36569	Peripheral (PICC)	Over	Without port or pump
⊙36570	Peripheral	Under	With subcutaneous port
⊙36571	Peripheral	Over	With subcutaneous port

Medicare Payment Information:

CPT[1]	Physician Work RVUs	Total RVUs Non-Facility	Total RVUs Facility	Global Days
⊙36568	1.92	9.91	2.85	000
36569	1.82	7.48	2.69	000
⊙36570	5.36	36.49	9.18	010
⊙36571	5.34	40.55	9.68	010

2013 RVUs

Device Repair Codes:

Repair of Central Venous Access Device			
CPT Code	**Tunneled vs. Non-tunneled**	**Central vs. Peripheral Insertion**	**With or Without Port or Pump**
36575	Tunneled or Non-tunneled	Central or Peripheral Insertion Site	Without pump or port
⊙36576	Tunneled	Central or Peripheral Insertion Site	With subcutaneous port or pump

Medicare Payment Information:

CPT[1]	Physician Work RVUs	Total RVUs Non-Facility	Total RVUs Facility	Global Days
36575	0.67	5.21	1.05	000
⊙36576	3.24	11.84	5.87	010

2013 RVUs

Device Replacement Codes: Partial Replacement

Central Venous Access Procedures

Partial Replacement of Central Venous Access Device (Catheter Only)			
CPT Code	**Catheter Only**	**Central vs. Peripheral Insertion**	**With or Without Port or Pump**
⊙36578	Tunneled or non-tunneled	Central or Peripheral Insertion Site	With subcutaneous port or pump

Medicare Payment Information:

CPT[1]	Physician Work RVUs	Total RVUs Non-Facility	Total RVUs Facility	Global Days
⊙36578	3.54	16.06	6.50	10

2013 RVUs

Device Replacement Codes: Complete Replacement

Complete Replacement of Central Venous Access Device Through the Same Venous Access Site			
CPT Code	**Tunneled vs. Non-tunneled**	**Central vs. Peripheral Insertion**	**With or Without Port or Pump**
36580	Non-tunneled	Centrally Inserted	Without subcutaneous port or pump
⊙36581	Tunneled	Centrally Inserted	Without subcutaneous port or pump
⊙36582	Tunneled	Centrally Inserted	With subcutaneous port
⊙36583	Tunneled	Centrally Inserted	With subcutaneous pump
36584	NA	Peripherally Inserted (PICC)	Without subcutaneous port or pump
⊙36585	NA	Peripherally Inserted	With subcutaneous port or pump

Medicare Payment Information:

CPT[1]	Physician Work RVUs	Total RVUs Non-Facility	Total RVUs Facility	Global Days
36580	1.31	6.56	1.98	000
⊙36581	3.48	23.72	5.89	010
⊙36582	5.24	34.36	9.17	010
⊙36583	5.29	43.02	10.08	010
36584	1.20	6.17	1.96	000
⊙36585	4.84	37.56	8.56	010

2013 RVUs

Central Venous Access Procedures

Device Removal Codes:

Removal of Central Venous Access Device			
CPT Code	**Catheter Only**	**Central vs. Peripheral Insertion**	**With or Without Port or Pump**
36589	Tunneled	NA	Without subcutaneous port or pump
⊙36590	Tunneled	Central or Peripheral Insertion	With subcutaneous port or pump

Medicare Payment Information:

CPT[1]	Physician Work RVUs	Total RVUs Non-Facility	Total RVUs Facility	Global Days
36589	2.28	5.01	4.19	010
⊙36590	3.35	8.93	6.17	010

2013 RVUs

Mechanical Removal Codes:

Mechanical Removal of Obstructed Material			
CPT Code	**Obstruction**	**Central vs. Peripheral Insertion**	**Separate Venous Access or through Device Lumen**
36595	Pericatheter obstructive material such as fibrin sheath	NA	Separate venous access
36596	Intraluminal (intracatheter) obstructive material	NA	Through device lumen

- Do not report 36596 with 36593
- Report 75902 for radiological supervision and interpretation

Medicare Payment Information:

CPT[1]	Physician Work RVUs	Total RVUs Non-Facility	Total RVUs Facility	Global Days
36595	3.59	17.35	5.48	000
36596	0.75	4.11	1.35	000

2013 RVUs

Central Venous Access Procedures

Repositioning Code:

CPT Code	Other Central Venous Access Procedures
36597	**Repositioning Previously placed central venous catheter under fluoroscopic guidance** Report 76000 for fluoroscopic guidance

Medicare Payment Information:

CPT[1]	Physician Work RVUs	Total RVUs Non-Facility	Total RVUs Facility	Global Days
36597	1.21	3.79	1.79	000

2013 RVUs

Radiologic Evaluation:

CPT Code	Other Central Venous Access Procedures
36598	Contrast injection(s) for radiologic evaluation of existing central venous device, including fluoroscopy, image documentation and report.

- Do not report 36598 in conjunction with 76
- Do not report 36598 in conjunction with 36595 or 36596
- See 75820, 75825, 75827 for complete diagnostic studies.

Medicare Payment Information:

CPT[1]	Physician Work RVUs	Total RVUs Non-Facility	Total RVUs Facility	Global Days
36598	0.74	3.33	1.07	000

2013 RVUs

Vascular Access Imaging

CPT Code	Description	2013 RVUS
+77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)	Global RVUs: 3.58 TC: 3.04 26: 0.54
+76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)	Global RVUs: 1.08 TC: 0.65 26: 0.43

2013 RVUs

Coding Tips

- Report CPT code 77001 (fluoroscopic) and/or CPT code 76937 (ultrasound) when surgeon performs image guidance for gaining access to the venous entry site or for manipulating the catheter into final central position
- Codes 77001 and 76937 are add-on codes; these codes are not subject to a multiple procedure payment reduction.
- Report the appropriate central venous access procedure(s) described with CPT codes 36555-36585.
- List the vascular access procedure as the primary code and list the add-on code subsequent to the vascular access code on the claim form.
- CPT codes 77001 and 76937 have a professional and technical component; Append modifier 26 for the professional component when the services are performed in a "facility" setting.
- Document a separate written report for the professional interpretation of CPT codes 77001 and 76937.

General Surgery Coding Alert

To subscribe call 800/508-2582 2011; Volume 13, Number 11

Reader Question: 44202 Hinges on Medical Necessity

Question: *Our surgeon performed a complex repair for a recurrent ventral hernia that involved taking down dense adhesions and removing old mesh. In the process, the op note describes three enterotomies resulting in a small bowel resection. Which services are separately billable?*

Texas Subscriber

Answer: Selecting the proper code for the hernia repair requires some information you don't provide. In addition to what you do state -- recurrent ventral hernia -- you also need the following data:

- Is it reducible? The contents of a reducible hernia can be pushed back through the fascial defect. In contrast, the contents of an incarcerated or strangulated hernia are trapped in the hernia sac and cannot be pushed back through the fascial defect.
- Open or laparoscopic? CPT® provides distinct hernia-repair codes based on the approach.

Once you've answered those questions from the surgical report, you can choose one of the following codes to describe the primary procedure:

- 49565 -- *Repair recurrent incisional or ventral hernia; reducible*
- 49566 -- *... incarcerated or strangulated*
- 49652 -- *Laparoscopy, surgical, repair, ventral, umbilical, spigelian, or epigastric hernia (includes mesh insertion, when performed); reducible*
- 49653 -- *... incarcerated or strangulated.*

Separate resection? Whether you can separately bill the small bowel resection using a code such as 44202 (*Laparoscopy, surgical; enterectomy, resection of small intestine, single resection and anastomosis*) depends on documentation.

If your surgeon makes it very clear that he could not deal with the adhesions without damaging the bowel, the resection would be medically necessary and therefore billable.

On the other hand: If the surgeon simply states "in the course of taking down dense adhesions, several enterotomies were made requiring small bowel resection, which was performed without difficulty," you shouldn't

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separately bill the resection.

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