

HB 10-1332 Colorado Medical Clean Claims Transparency and Uniformity Act Task Force

Agenda

September 26, 2012, noon – 2 pm MST

Call-in number: 1-866-740-1260, ID 8586328 #

Web Login: <https://cc.readytalk.com/cc/s/showReg?udc=fgtc1fbst3kd>

Agenda

- 12:00 PM Roll call, welcoming remarks and housekeeping
- Approve August 2012 meeting minutes (Attachment A)
 - Next face to face meeting October 23-24

Committee Reports

Committee Reports: introduce committee members; committee principles (if applicable); committee scope of work; report of activities to date; recommendations (draft and final); issues to be resolved or investigated; questions for the full task force; next steps.

- 12:10 PM Committee Reports
- Data Sustaining Repository – Mark Rieger/Val Clark
 - Discussion of DSR Long Term Business Model (Attachment B to be sent prior to meeting)
 - Edit– Beth Wright/Mark Painter
 - Modifier Table Progress (Attachment C)
 - Rules Committee – Lisa Lipinski
 - Pricing Rule Definition
 - Pricing Rule Guideline
 - Modifier Definition (Attachment D) **CONSENSUS ITEM**
 - Specialty Society – Tammy Banks/Helen Campbell
 - Project Management – Barry Keene
 - Draft Outline of Report to the Legislature (Attachment E)
 - RFP Progress, draft at website
 - Finance – Barry Keene/Foundations Meeting
 - State Innovation Model (SIM) Grant Application
 - Colorado Health Foundation Grant Status
- 1:50 PM Other Business
- 1:55 PM Public Comment
- 2:00 PM **ADJOURNMENT**

Attachment A

DRAFT

HB10_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT TASK FORCE

Meeting Minutes

August 22, 2012

Noon - 2 PM, MST

Call-in Number: 1-866-740-1260

Conference ID: ID 8586328

Attendees:

- Amy Hodges
- Barry Keene, CC
- Beth Provost, alternate
- Dee Cole, alternate
- Doug Moeller, MD
- Jill Roberson
- Kathy McCreary
- Kim Davis
- Lori Marden
- Marie Mindeman
- Marilyn Rissmiller, CC
- Mark Painter
- Mark Rieger
- Michelle Schrader
- Tammy Banks, alternate
- Tom Darr, MD
- Wendi Healy

Staff :

- Laura Powers
- Barbara Yondorf

Public:

Beth Kujawski
Chris Becker
Lisa Lipinski
Marianne Fink
Mary Evans
Sherry Smith
Tanya Padilla

Meeting Objective (s):

Key:

- TF = Task Force
- TFM = Task Force Member
- CC = Co-Chair

Parking Lot:



TOPIC	DISCUSSION	ACTION ITEM	DUE DATE
<p>Welcome & Roll Call & Housekeeping</p>	<p>ROLL CALL & WELCOME: 17 Task force Members in attendance, quorum met</p> <p>Approve July 2012 meeting minutes (Attachment A) Marilyn: Tammy and Lisa Lipinski submitted revised comments. Minutes were approved with no other revisions.</p> <p>Move to approve by Barry Keene, seconded by Mark Rieger and approved by the task force.</p> <p>2012 Meeting Schedule (Attachment B)</p> <p>Marilyn: The new November 14 and December 19 meeting dates have been added to the schedule.</p> <p>Barry: Please note that the October full task force meeting has been moved to Tuesday the 23rd and Wednesday the 24th. These start at noon on Tuesday until 6 and the next day 8 until 3 pm. These will be at COPIC building where Colorado Medical Society has a facility. This is a change in location from previous meetings.</p> <p>In Scope/Out-of-Scope language (attachment C)</p> <p>Marilyn: Any comments on Attachment C with the revisions?</p> <p>None given</p> <p>Barb: Please note your name when speaking since this is a telecall. Members of the public can give comments at the end of the call.</p> <p>Barry: A number of members of the public attending as well as several representatives of Colorado Chapter Radiological Society (CRS). Dr. Jim Borgstede has applied to be a member of the task force. Will get this to Director Birch at HCPF to get him officially approved. Since he is in the process of becoming a full task force member, he does not need to wait until the public portion of the meeting.</p> <p>Jim: Thanked the committee for the opportunity to participate.</p>		

<p>Committee Reports</p>	<p>DSR (DATA SUSTAINING REPOSITORY)- MARK RIEGER</p> <p>Mark Rieger: DSR did not meet in July or August and in conversation to resolve the conflict of interest concerns. Beginning in September the DSR committee should be back on track. At this point, there is already work being done in the final stages of the RFP process. One thing to resolve was my role as co-chair and as one of the vendors. We have resolution on that.</p> <p>Barry: Mark did stand down at a place when there was a potential conflict. We felt prudent to limit the amount of input that that committee had for the RFI. Subsequently, we received many good responses to the RFI process and are now on to the RFP. Part of the legislation has to do with the database and how it will be sustained in perpetuity. Vendors were polled to see if there was a perceived conflict and what the DSR would look like. Colorado needed to use the best experts available and to use them to determine what a sustaining model would look like. None of those polled had an issue with this. We are going to continue and work on creating the sustaining model. Can we touch on the types of business models that would be possible?</p> <p>Mark Rieger: I would open it up to the group to hear from other members of the task force to frame up the agenda. I will start with a few thoughts I've had. We did contemplate some options for the infrastructure costs to determine what would be the costs. General consent that this would need to be funded through the private sector. Commitment that there would be no new dollars required but rather reallocating dollars that are already being used.</p> <p>Doug Moeller: Chicken and egg scenario here that the committee has struggled with. It depends on what services are provided. If they are a feed only repository then that is one layer, if there is interactive data transfer open then that is another option. If there is to be an interactive part then this needs to be set-out. Three areas of funding: 1 is public from legislative or agency funding (Colorado is not seeming to go in this direction) 2) Foundation support which we've had so far 3) Private from those who would benefit from these services. Looks like we are going to have a combination of these three. Propose looking at different scenarios that would be possible.</p>		
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Barry: NCCI edit set is an example of the public option. There can be licensing fees to help fund this. Discussed the potential for going beyond NCCI and having claims run through this. We need to put numbers around the cost to run it. I'd like to see several business model scenarios and we need to do this quickly since we have a deadline for the report in December to HCPF (Health Care Policy and Financing).

EDIT COMMITTEE – BETH WRIGHT/MARK PAINTER

Mark Painter: Beth cannot attend this meeting. Discussing the reformatted Other Edit Types document (Attachment D). Changed the type of edit in the description and added a more detailed out-of-scope rationale. All of these came from Medicaid and added our own reasons as to why out of scope. The other meeting we had surrounded the discussion of radiology and the multiple procedure reduction. We had a large representation from the CRS and the American College of Radiology (ACR). We did have some members from the Rules Committee in that discussion. Much of that needs to be determined by the Rules Committee. There is more discussion that needs to happen in future meetings.

Marilyn: Added a list of examples. She thought most of these came from Medicaid, but may be used by other payers as well. Does this format make sense for everyone? The out-of-scope list is not final but is a work in progress.

Mark P: We did try to categorize them, so far we have identified administrative and benefit edits. One of the things that was apparent as heard from ACR, is that we need to develop is some type of protest protocol or discrepancy discussion. We need a process for those who have a disagreement with our decision to address in a formal way. Not sure if this belongs with the Rules Committee, Edit Committee or elsewhere.

Tammy: You are calling the edit category manual pricing required but it is how should bilateral modifier be reported. That part is already defined as a code edit. Are you just talking about how a payer processes?

Mark P: Yes this is specific to how Medicaid processes Medicare crossover claims for bilateral that is out-of-scope.

	<p>Marilyn: Bilateral is only listed as an example, not saying that bilateral is the type of edit. We haven't figure out where the protest protocol belongs but we are aware of this.</p> <p>RULES COMMITTEE – LISA LIPINSKI/HELEN CAMPBELL</p> <p>Lisa: Met to discuss what a payment rule is and review examples. Would like to bring consensus for this at the next task force meeting. We will also provide modifier definitions. Right now we are looking at CPT modifiers and are looking for other modifiers that would either decrease or increase payments for consideration.</p> <p>Barry: Can you give an overview of the committee, who is joining, etc?</p> <p>Lisa: Standard meeting schedule should be out by end of month and will be meeting twice monthly. Once at the beginning and one at the end. Anyone is willing to join. Helen Campbell, Wendi Healy, Marilyn Rissmiller, Beth Wright, Mark Painter, Marie Mindeman, Amy Hodges, Dr. Borgstede, Lisa Lipinski.</p> <p>Barry: Lisa is handling communication. I had a meeting with our webmaster about adding a blog and front end page – all subcommittees to have a webpage in the password protected area. We will add that for your committee.</p> <p>Jim Borgstede: Just want to note that we did discuss that the multiple procedural percentage reduction was distinctly different from the bilateral issue.</p>	<p>Send out meeting schedule for Rules Committee</p> <p>Member interested in participating in Rules Committee should contact Lisa Lipinski</p>	<p>Prior to next Full Task Force Meeting on 9/26</p>
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SPECIALTY SOCIETY – TAMMY BANKS/HELEN CAMPBELL

Tammy: Last month we got a letter out to the National Specialty Societies about the CPT code pairs and the task force. Have been fielding questions from various specialty societies.

Barry: I wonder how many specialty societies you went to?

Tammy: 122 National Specialty Societies and 50 state medical societies. Sent to CEOs and staff and the RUC (American Medical Association/Specialty Society RVS Update Committee) representatives.

Barry: Can this be posted on the public side of the website?

Tammy: yes

Barry: When we met with state radiology group we received message that they had not heard from us. As we grow and work becomes more significant, we want to make sure we include everyone who is affected by this. Marilyn is considering when and how to go out to the state specialty societies. Was a little bit surprised and concerned that our local radiologists didn't know what we were doing. Anything that we can do to help this would be good.

Marilyn: Understood what Tammy had been saying. What is the ask from the task force and how do we want to receive that? Do we want it to go to Tammy or to the general task force email?

Barry: I believe it should come back through Tammy Banks and Helen Campbell. Tammy how do you feel about that?

Tammy: That is fine – some of the specialty societies had a hard time understanding what we are doing. We do not have information on the state specialty societies.

Jim Borgstede: While the national ones are a great resource, this is a Colorado resource and requirement. Some of the national ones may have a limited ability to help on a state scale.

Marilyn: Want to figure out how to get input from Colorado and National level.

Jim Borgstede: Doesn't the national organization have the level for the state specialty societies? I'd rather the societies have input at this stage rather than wait until after the decisions are made and it is after-the-fact.

Marilyn: Just want clarification on the communication aspect. If everyone is in agreement, that the AMA continues outreach at the National level and the CMS at the state level.

Barry: Need to send out a package and we will reach out at the local level.

Marilyn: Needs background as well as the letter for input. We want edits that you think are appropriate or not support.

Tammy: It needs to be a specific ask. They are not going to understand unless they have something specific.

Marilyn: I think we need to provide examples.

Marie: CPT has robust process for their submissions.

Marilyn: I will work with Marie and Tammy on this language.

PROJECT MANAGEMENT- BARRY KEENE

Barry: Tammy if you could be so kind as to resend the letter. Principal thing is the RFP letter that still isn't right quite ready but will be soon. This is for the Phase 1 or the tool set that will allow us to do the development work. It is data analytics. Software we would be using is SAAS or software as a service. This is not the next phase which is what we are required to recommend. The RFP is for the first thing. The edit group and data that comes out of this set of analytics will contribute to the long-term Data Sustaining Repository. We have taken a lot of material that will include our scoring detail with our RFP. There are a lot of legal issues that need to be looked at. We will be sending this out to the task force by this Friday. We are looking for things that we may have missed, or what needs to be clearer. Hope to have this back by after labor day. We'd like a final draft for the September meeting. It will go to the original recipients of the RFI as well as additional recipients. Look for this coming from me or Barry. Any questions?

RFP to be sent out

**Next TF meeting
September 26**

	<p>One other brief topic – our fiscal sponsor. Our sponsorship will be moving from Bell Policy to Colorado Health Institute. We have hit the summer holiday which has slowed us down. Amy Downs, one of their principals has been aware of this before it was even legislation. We do look forward to getting this taken care of soon. This does play into our next round of funding. Any questions?</p> <p>FINANCE – BARRY KEENE</p> <p>Barry: There are a lot of things active right now. Met with Laura Girard at Colorado Health Foundation. She had a series of questions and also will let us know where we stand within a couple of weeks. They believe our data analytics need to be funded by stakeholders at the table. We need to be looking to our stakeholders and we have been working on this angle. Some may have heard from me about this. Colorado Hospital Foundation is interested and they have volunteered to fund catering for October meeting. They are going to look more thoughtfully to see if they can contribute in cash as well. We also had an interesting conversation, with the AAPC (American Academy of Professional Coders) Wendi put together a nice slide set and ran a half hour meeting with them. Asked if they might contribute and they would like to provide a webinar where we can present what we are doing to their contacts. They had a nice article about what we are doing last year. They are unable to contribute to donate since they are a national organization and if there were other states doing something similar then they would feel obliged to contribute to them as well. If we expect to receive additional funding from the Colorado Health and other foundations, we are going to need to raise private funds. We are working on innovation and transformation funding through the Affordable Care Act through the data integration and quality group with HCPF. I believe that this is the money that she was implying about when Sue Birch spoke with us last month. We need to stay visible to keep them informed about just how important this work is. We may get some federal funding but it is at arms-length right now.</p>		
	<p>OTHER BUSINESS</p> <p>Marilyn: Any other business?</p> <p>No other business was addressed.</p> <p>Next meeting full committee meeting September 26th.</p>		

	<p>PUBLIC COMMENT</p> <p>Marilyn: Any comments?</p> <p>None given</p> <p>Barry: Commented that most of the heavy lifting does happens in the subcommittees. A co-chair must be a seated full committee member but the subcommittees are open to public participation. The DSR subcommittee needs not just the software but the payers and the providers as well.</p> <p>Meeting adjourned at 1:19</p>		
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Attachment C - Modifiers

Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
Modifier 22: Increased Procedural Services	<p>Description: 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.</p>	<p>Payment modifier Doesn't override edits Documentation required – claim pended; reviewed to determine if additional payment allowed; some payers pay a flat %;</p> <p>some carriers don't consider it a clean claim if it isn't submitted; others just consider the claim as if -22 weren't submitted</p> <p style="color: red;">Modifier rules to be handled by Payment rule committee</p>	<p>Guideline</p> <ul style="list-style-type: none"> • Use only when work factors requiring the physician's technical skill involve significantly more <ul style="list-style-type: none"> – Work – Time – Complexity • For surgical and nonsurgical procedures • Use this modifier when the work required to provide a service is substantially greater than typically required. <ul style="list-style-type: none"> – It may be identified by adding modifier 22 to the usual procedure code • Documentation must support the <ul style="list-style-type: none"> – Substantial additional work and reason for the addition work – ie, increased intensity, time, technical difficulty of the procedure, severity of patient's condition, physical and mental effort required • May be used in these CPT code set sections <ul style="list-style-type: none"> – Anesthesia – Surgery – Radiology – Laboratory and pathology – Medicine 	<p>Carriers continue to have authority to increase payment for unusual circumstances based on review of medical records and other documentation. Modifier 22 may be reported when services provided are greater than that usually required for the listed procedure. Documentation of the unusual circumstances must accompany the claim (eg, a copy of the operative report and a separate statement written by the physician explaining the unusual amount of work required).</p> <ul style="list-style-type: none"> • Relative value units for services represent average work effort and practice expenses for a service • Increased or decreased payment only under unusual circumstances and after medical records and documentation review • Claim submission requirements <ul style="list-style-type: none"> – Concise statement about how the service differs from the usual – Operative report
Modifier 23: Unusual Anesthesia	<p>Description: 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 modifier 23 to the procedure code of the basic service.</p>	<p>Payment modifier Doesn't override edits</p> <p style="color: red;">Modifier rules to be handled by Payment rule committee</p>	<p>Guideline</p> <ul style="list-style-type: none"> • Used when a procedure which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia • Appended to the procedure code of the basic service • Anesthesia administration may be reported with <ul style="list-style-type: none"> – Anesthesia CPT codes – Anesthesia modifier – Qualifying circumstance codes • Some payers do not accept anesthesia codes; instead require use of codes from Surgery section of 	<ul style="list-style-type: none"> • Examples of typical anesthesia services <ul style="list-style-type: none"> – Preoperative and postoperative visits by the anesthesiologist – Intraprocedural anesthesia care – Insertion of airways and intravenous lines – Intraoperative interpretation of perioperative laboratory tests • Examples of medically necessary surgical and medical services provided by

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Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
			<p>CPT codebook</p> <ul style="list-style-type: none"> • For reporting anesthesia services given by or under supervision of a physician • Examples of included services <ul style="list-style-type: none"> – General or regional supplementation of local anesthesia – Usual preoperative and postoperative visits – Intra-procedural anesthesia care – Usual monitoring services • To report conscious sedation, see codes 99143-99150 <p>Reporting Anesthesia Services</p> <ul style="list-style-type: none"> • Anesthesia services always included in CPT surgical codes <ul style="list-style-type: none"> – Local infiltration – Metacarpal, metatarsal, or digital block – Topical anesthesia • When to append modifier 23 <ul style="list-style-type: none"> – For a procedure that usually requires no or local anesthesia but must be done under general anesthesia • Anesthesia services must be provided by or under physician supervision to be reported <p>Physician Status Modifier</p> <ul style="list-style-type: none"> • All anesthesia services are reported by means of <ul style="list-style-type: none"> – 5-digit anesthesia modifier procedure code (00100-01999) and – Physical status modifier (P1-P6), appended directly to all anesthesia codes • Other modifiers may be appropriate when procedural services are coded and reported in addition to the anesthesia procedure code 	<p>anesthesiologists</p> <ul style="list-style-type: none"> – Swan-Ganz catheter insertion (93503) – Central venous pressure line insertion (36555-36571) – Intra-arterial line insertion (36620-36625) <ul style="list-style-type: none"> • To be submitted with the claim for payment <ul style="list-style-type: none"> – Surgeon's operative note, including • Surgical time • Medications administered <ul style="list-style-type: none"> – Anesthesia record, including • Anesthesia time • Monitors applied • Medications administered by anesthesia • Documentation of monitor readings <ul style="list-style-type: none"> • Documentation to support unusual anesthesia <ul style="list-style-type: none"> – Detailed description of the reason the case is unusual – Submit documentation with the claim
Modifier 24:	Description: The physician may	Payment modifier	Guideline	This modifier is primarily intended got use by

Attachment C - Modifiers

Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period	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.	Can override an edit --- 'G' global surgery days	<ul style="list-style-type: none"> • The E/M service must be unrelated to the surgery but provided within the global care postoperative period • Patient care has been performed by the same physician for surgery and the E/M service • Appropriate for usage when physician provides a surgical service related to one problem, and during the postoperative period provides an E/M service unrelated to the problem requiring surgery • Used only with E/M services in the CPT codebook • Selection of the diagnosis code critical when indicating reason for E/M service 	<p>the surgeon. In most circumstances, subsequent hospital care (99231-99233) provided by the surgeon during the same hospitalization as the surgery will be considered by the carrier to be related to the surgery. Separate payment for such visits will not be made, even if reported with modifier 24, unless documentation is submitted demonstrating that the care is unrelated to the surgery. Two exceptions to this policy are for treatment provided by immunotherapy management furnished by the transplant surgeon and critical care for a burn or trauma patient. Modifier 24 should be reported in these situations and appropriate documentation submitted with the claim.</p> <p>When a visit is provided in the outpatient setting, and ICD-9_CM code indicating why the encounter is unrelated to the surgery may be sufficient documentation if it is clear the service is unrelated, If the ICD-9-CM code does not make this clear, a brief narrative explanation is required. Carriers will review all claims submitted with the 24 modifier.</p> <ul style="list-style-type: none"> • Sufficient documentation required to show that the E/M service submitted with modifier 24 was unrelated to the surgery • Diagnosis must support that the claim is unrelated to initial procedure • For codes 99291 and 99292 to be paid during preoperative or postoperative period with modifier 24, submitted documentation must show that critical care was unrelated to the injury or surgery

Attachment C - Modifiers

Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
				<ul style="list-style-type: none"> • Modifier 24 is not recognized for an unrelated E/M service during the postoperative period unless: • The care for immunotherapy management furnished by transplant surgeon • The care is for critical care for a burn or trauma patient • The documentation demonstrates that the visit occurred during a subsequent hospitalization, and the diagnosis supports the fact that it is unrelated to the original surgery
Modifier 25: Significant Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service	Description: 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 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 Services Guidelines for instructions on	Payment modifier Can override an edit: <ul style="list-style-type: none"> • A=Unbundle (NCCI) • B =Mutually exclusive edit <ul style="list-style-type: none"> ◦ Inc. 2 E&Ms • F=Frequency (2 E&Ms) • G=Global Surgery days 	Guideline <ul style="list-style-type: none"> • Physician may need to indicate that on the day of procedure or service was performed patient's condition required a significant, separately identifiable E/M service • E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided • Different diagnosis not required for reporting of the E/M service • Documentation must support the E/M level selected • Modifier 25 used to indicate that a significant, separately identifiable E/M service was performed by the same physician on the day of procedure • CPT guidelines <ul style="list-style-type: none"> – E/M service must meet the key components • Correct use of modifier 25 <ul style="list-style-type: none"> – The E/M service level needs to be supported by adequate documentation 	Modifier 25 can be used with preventive medicine codes. When a significant problem is encountered while performing a preventive medicine E/M service, requiring work to perform the key components of the E/M service, the appropriate office outpatient code also should be reported for that service with the modifier 25 appended. Modifier 25 allows separate payment for these visits without requiring documentation with the claim form. <ul style="list-style-type: none"> • CMS recognizes use of modifier 25 with E/M services in several codes <ul style="list-style-type: none"> – 99201-99499 – 92002-92014 – HCPCS codes G0101-G0175 • Use only for provision of a significant, separately identifiable E/M service on the same day as a minor surgical procedure • Documentation on patient's medical record

Attachment C - Modifiers

Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
	<p>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 services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.</p> <p>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.</p>		<ul style="list-style-type: none"> – E/M service can occur at same visit when a surgical procedure is performed – Not restricted to a particular level of E/M service <p>Supportive Phrasing for Modifier 25</p> <ul style="list-style-type: none"> • “The patient’s condition required” <ul style="list-style-type: none"> – A key for deciding whether modifier 25 applies – Tells the insurance carrier of the medically necessary services on the same day that another procedure or service was performed • “A significant, separately identifiable E/M service above and beyond” the other service provided <ul style="list-style-type: none"> – Indicates the additional service was clearly different from the other procedure/service performed • Modifier 25 used when a significant problem is encountered while a preventive medicine service is performed, requiring additional work to perform the key components, appropriate outpatient code should also be reported with modifier 25 appended <ul style="list-style-type: none"> • Modifier 25 allows separate payment for these visits <ul style="list-style-type: none"> • Critical care services must be unrelated to the specific anatomic injury or surgical procedure performed • Documentation that the critical care is unrelated must be submitted to the carrier for review <ul style="list-style-type: none"> • Modifier 25 can be used for symptoms encountered during a preventive medicine visit that require substantial extra work for a 	<ul style="list-style-type: none"> – Expected to be clearly evident that the E/M service performed and billed was “above and beyond” the usual preoperative and postoperative care associated with the procedure performed on same day <ul style="list-style-type: none"> – Should indicate an important, notable, distinct correlation with signs and symptoms to make a diagnostic classification or demonstrate a distinct problem • Questions for determining if work goes above and beyond usual pre- and postoperative work: <ul style="list-style-type: none"> – Is the work more than the usual preoperative and postoperative work? – Does the complaint or problem stand alone as a billable service? – Did the physician perform and document the key components of an E/M service for the complaint or problem? – Is there a different diagnosis for the significant portion of the visit? If not, was the extra work more than the usual? • National Correct Coding Initiative (NCCI) developed by CMS to <ul style="list-style-type: none"> – Promote correct coding methods – Control improper coding • CMS will not reimburse for an E/M service in addition to the procedure when the service resulted in performance of a minor surgical procedure (with a 10-day global period) on the same date

Attachment C - Modifiers

Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
			<p style="text-align: center;">problem-oriented E/M service</p> <ul style="list-style-type: none"> • Many carriers pay for only the preventive service when two E/M services (well and problematic) are billed during the same patient encounter 	
<p>Modifier 26: Professional Component</p>	<p>Description: 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 modifier 26 to the usual procedure number</p>	<p>Payment modifier Can override edits:</p> <ul style="list-style-type: none"> • F – Frequency edits <p>Important to total/26/TC (M) editing When billed appropriately</p>	<p>Guideline</p> <ul style="list-style-type: none"> • Complete service <ul style="list-style-type: none"> – The physician provides the entire service including the equipment, supplies, technical personnel, and the physician’s professional services – Can be divided into technical and professional components • HCPCS level II modifier TC: <ul style="list-style-type: none"> – Identifies the technical component <p>Pathology Services for CMS</p> <ul style="list-style-type: none"> • Billing for anatomical and surgical pathology services (both technical and professional components) must comply with: <ul style="list-style-type: none"> – The contractual arrangements between the facility and the pathologist – Medicare, Medicaid, and other third-party payer requirements • Options for billing pathology services <ul style="list-style-type: none"> – Bill technical component only – Do not bill either component – Bill globally • For independent laboratory billing for technical component of physician pathology services to hospital patients • Medicare carriers can pay the technical component of pathology services when: <ul style="list-style-type: none"> – An independent laboratory provides services to an inpatient or outpatient of a covered hospital – The laboratory provided the technical component of 	<ul style="list-style-type: none"> • Definition of a Complete service <ul style="list-style-type: none"> – The physician provides the entire service including the equipment, supplies, technical personnel, and the physician’s professional services – Can be divided into technical and professional components • HCPCS level II modifier TC: <ul style="list-style-type: none"> – Identifies the technical component

Attachment C - Modifiers

Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
			physician pathology services	
Modifier 32: Mandated Services	Description Services related to <i>mandated</i> consultation and/or related services (eg, third party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.	Considered informational (has been recommended to be used when translator services were required)	Guideline Include examples of parties that may request a mandated service	Modifier 32 with claims has no effect on reimbursement
Modifier 33: Preventive Services	Description: When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.	Payment modifier Doesn't override edit Used for benefit Could be considered for procedure to modifier editing		
Modifier 47: Anesthesia by Surgeon	Description: Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures.	Informational – Not a payment modifier Doesn't override edit Not really used by payers – Most don't allow anesthesia by surgeons	Guideline Local anesthesia not included: is already in the surgical package <ul style="list-style-type: none">• Modifier not for use if surgeon monitors general anesthesia provided by: intern, resident, certified RN anesthetist, anesthesiologist	– Does not recognize modifier 47 – Does not cover anesthesia services provided by the surgeon or physician separately
Modifier 50:	Description: Unless otherwise	Payment modifier	Guideline	The bilateral modifier is used to indicated

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Bilateral Procedure	identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.	<p>Critical to editing – N- Bilateral procedures</p> <p>Refer to payment rules committee for rules about how to bill.</p>	<p>The use of this modifier is only applicable to services or procedures performed on identical anatomic sites, aspects, or organs (eg, arms, legs, eyes) during the same operative session. The intent is for the modifier to be appended to the appropriate unilateral code as a single-line entry on the claim form to indicate that the procedure was performed bilaterally.</p> <p>When a procedure is reported with modifier 50 appended to the code, the units box on the claim form should indicate that 1 unit of service was provided because the procedure was performed bilaterally.</p> <p>Although this reporting method reflects the intent of CPT coding guidelines, local third-party payer reporting guidelines may require that the code be listed twice, with modifier 50 appended to the second line entry. Third-party payers should be contacted for their respective reporting guidelines.</p> <p>Copyright 2007, American Medical Association</p> <p>It is not appropriate to append the modifier 50 to those CPT codes having descriptors representing a technique that may inherently involve physiology or anatomy on both the left and right side of the body. You will also note that the CPT code descriptors for these procedures/services may either:</p> <ul style="list-style-type: none"> <input type="checkbox"/> specifically state the procedure/service may be performed either unilaterally or bilaterally (eg, 58900, Biopsy of ovary(s)); or <input type="checkbox"/> specify the procedure is "bilateral" (eg, 78458, Vein thrombosis images, bilateral); or, <input type="checkbox"/> reflect multiple anatomy (eg, 73520, X-ray exam of hips). <p>It is not appropriate to append modifier 50 to the radiology procedure (70000 series) codes, as there are</p>	<p>cases in which a procedure normally performed on only one side of the body. The CPT descriptors for some procedures specify that the procedure is bilateral. In such cases, the bilateral modifier is not used for increased payment. Medicare has maintained the policy of approving 150% of the global amount when the bilateral modifier is used. If additional procedures are performed on the same day as the bilateral surgery, they should be reported with modifier 51. The multiple surgery rules apply, with the highest valued procedure paid at 100% and the second through fifth procedures paid at 50%. All others beyond the fifth are paid on a by report basis.</p> <p>When identical procedures are performed by two different physicians on opposite sides of the body or when bilateral procedures requiring two surgical teams working during the same surgical session are performed, the following rules apply : The surgery is considered cosurgery (see modifier 62) if CPT designates the procedure as bilateral (eg, 27395). The CMS payment rules allows 125% of the procedure's payment amount divided equally between two surgeons. If CPT does not designate the procedure as bilateral, CMS payment rules first calculate 150% of the payment amount for the procedure. Then the cosurgery rule is applied; split 125% of that amount between the two surgeons.</p>

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			other modifiers to designate separately identifiable procedures (eg, modifier 59). The use of specific modifiers is carrier dependent.	
Modifier 51: Multiple Procedures	<p>Description: 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).</p> <p>Note: This modifier should not be appended to designated “add-on” codes (see Appendix D).</p>	<p>Informational WellPoint and Rocky Mtn -don't use to drive MPR Humana will check Amy – some large clients use it in payment process --- provider not required to use CMS – informational</p>	<p>Guideline The modifier 51 does not apply to E/M codes, designated add-on codes, or codes designated as modifier 51 exempt (see Appendix F). The use of the modifier 51 is not restricted to operative procedures, although it is commonly used in this context. To alleviate confusion about the intent of the modifier, the definition includes language to indicate that it is not appended to add-on codes, as listed in Appendix D of the CPT codebook, E/M codes, or codes designated as modifier 51 exempt, as listed in Appendix E of the CPT codebook. To assist in determining is appropriate usage, modifier 51 has four applications, namely to identify:</p> <ul style="list-style-type: none"> o Multiple medical procedures performed at the same session by the same provider; o Multiple, related operative procedures performed at the same session by the same provider; o Operative procedures performed in combination at the same session, by the same provider, whether through the same or another incision or involving the same or different anatomy; and o A combination of medical and operative procedures performed at the same session by the same provider. <p>Modifier 51 is generally not reported with the 70000 series codes. The use of the multiple procedure modifier 51 in the 70000 series of codes is applied only to the nuclear medicine codes 78306, 78320, 78802, 78803, 78806, and 78807.</p>	<p>Medicare payment policy is based on the lesser of the actual charge or 100% of the payment schedule for the procedure with the highest payment, while payment for the second through fifth surgical procedures is based on the lesser of the actual charge or 50% of the payment schedule. Surgical procedures beyond the fifth are priced by carriers on a “by-report” basis. The payment adjustment rules do not apply if two or more surgeons of different specialties (eg, multiple trauma cases) each performs distinctly different surgeries on the same patient on the same day. The CMS has clarified that payment adjustment rules for multiple surgery, cosurgery, and team surgery do not apply to trauma surgery situations when multiple physicians from different specialties provide different surgical procedures, modifier 51 is used only if one of the same surgeons individually performs multiple surgeries.</p> <p>For 2011, the criteria for procedures and services to be included on the modifier 51 exempt list were clearly defined. First and foremost, all add-on codes, physical medicine and rehabilitation services, and vaccines have been excluded from being able to be coded with modifier 51. Another criterion is that the services on this list should have minimal preservice time and postservice time. Because the preservice and postservice activities of services performed together should not be replicated, only codes with minimal amounts of</p>

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				preservice and postservice time have been retained on this list. Additionally, services that are currently subject to multiple surgery reduction have been removed from the list to be consistent with Medicare payment policy.
Modifier 52: Reduced Services	Description: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. 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. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as 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).		Guideline <ul style="list-style-type: none"> • Appended when service/procedure partially reduced or eliminated at the physician's discretion • Not for elective cancellation of a procedure prior to anesthesia induction and/or surgical preparation in the operation suite 	Carriers continue to have authority to increase payment for decreased payment for reduced services based on review of medical records and other documentation. Documentation of the unusual circumstances must accompany the claim (eg, a copy of the operative report and a separate statement written by the physician explaining the unusual amount of work required). <ul style="list-style-type: none"> • For a procedure/service significantly less than usually required <ul style="list-style-type: none"> – Modifier 52 appended to procedure code • Medicare does not recognize modifier with E/M services • Modifier ignored if documentation and practitioner statement about service reduction are not submitted with the claim
Modifier 53: Discontinued Procedure	Description: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating		Guideline <ul style="list-style-type: none"> • Used to report circumstances when patients experience unexpected responses that cause procedure termination 	<ul style="list-style-type: none"> • Valid when attached to a surgical code or medical diagnostic code when the procedure was started but had to be discontinued • Not valid <ul style="list-style-type: none"> – For elective cancellation of a procedure

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	<p>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.</p> <p>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 as 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).</p>		<ul style="list-style-type: none"> • Not used for reporting ASC facility services <ul style="list-style-type: none"> – See modifiers 73 and 74 for ASC facility reporting 	<p>before anesthesia induction and/or surgical preparation in the operating suite</p> <ul style="list-style-type: none"> – For outpatient hospital or ASC reporting • Use modifier 73 or 74 for partially reduced or canceled procedure/service – For use with E/M service CPT codes – For conversion of laparoscopic or endoscopic procedure to open or when a procedure becomes more extensive
<p>Modifier 54: Surgical Care Only</p>	<p>Description: When 1 physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54</p>		<p>Guideline</p> <ul style="list-style-type: none"> • CPT surgery guidelines: surgical procedures include the operation and the following: <ul style="list-style-type: none"> – Local infiltration; metacarpal, metatarsal, or digital block; – topical anesthesia – One related E/M encounter 	<p>Used when more than one physician provides services that are part of a global surgery package.</p> <p>CMS policy allows a physician who assumes postsurgical responsibilities for a patient during the hospital stay to report subsequent hospital</p>

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	to the usual procedure number.		<p>on the day before or day of procedure, after deciding to do surgery</p> <ul style="list-style-type: none"> – Immediate postoperative care – Writing orders – Postanesthesia recovery evaluation – Typical postoperative follow-up care <p>• CMS and many third-party payers define global physician services as the following:</p> <ul style="list-style-type: none"> – Preoperative management – Surgical procedure – Postoperative management 	<p>visits in addition to the postsurgery portion of the global fee. Physicians assuming postsurgical responsibility should report appropriate subsequent hospital care codes for the inpatient hospital care and the surgical code with modifier 55 for the postdischarge care. The surgeon reports the appropriate surgery code with modifier 54.</p> <p>The surgeon's payment, which includes preoperative, intraoperative, and postoperative hospital services, is based on the preoperative and intraoperative portions of the global payment. Where more than one physician bills for postoperative care, however, the postoperative percentage of the global payment is apportioned according to the number of days each physician was responsible for the patient's care.</p> <p>When postoperative recovery care is split between several physicians, they must agree on the transfer of care. The agreement may be a letter or an annotation in the discharge summary, hospital record, or ambulatory surgical center (ASC) record. The physician assuming the patient's care reports the appropriate procedure code with modifier 55 but may not report any services included in the global period until at least one service has been provided. If the surgeon relinquishes care at the time of discharge, only the date of surgery needs to be indicated when billing with modifier 54. However, if the surgeon provides care after the patient is discharged, it is also necessary to show date of surgery, date of</p>

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				<p>discharge, and date on which postoperative care is relinquished to another physician.</p> <p>When a physician other than the surgeon provides occasional postoperative services during the global period, separate payment is allowed. These services should be reported with the appropriate E/M codes. Physicians report services provided and take particular care using correct ICD-9-CM codes. Payment is not included in the global fee as long as these services are occasional and unusual and do not reflect a pattern of postoperative care. However, separate payment is not allowed if the physician is the covering physician (eg, locum tenens) or part of the same group as the surgeon who performed the procedure and provided most of the postoperative care included in the global package.</p>
<p>Modifier 55: Postoperative Management Only</p>	<p>Description: When 1 physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.</p>		<p>Guideline</p> <ul style="list-style-type: none"> • CPT surgery guidelines: surgical procedures include the operation and the following: <ul style="list-style-type: none"> – Local infiltration; metacarpal, metatarsal, or digital block; topical anesthesia – One related E/M encounter on the day before or day of procedure, after deciding to do surgery – Immediate postoperative care – Writing orders – Postanesthesia recovery evaluation – Typical postoperative follow-up care 	<p>Used when more than one physician provides services that are part of a global surgery package.</p> <p>CMS policy allows a physician who assumes postsurgical responsibilities for a patient during the hospital stay to report subsequent hospital visits in addition to the postsurgery portion of the global fee. Physicians assuming postsurgical responsibility should report appropriate subsequent hospital care codes for the inpatient hospital care and the surgical code with modifier 55 for the postdischarge care. The surgeon reports the appropriate surgery code with modifier 54.</p> <p>The surgeon's payment, which includes</p>

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			<ul style="list-style-type: none"> • CMS and many third-party payers define global physician services as the following: <ul style="list-style-type: none"> – Preoperative management – Surgical procedure – Postoperative management 	<p>preoperative, intraoperative, and postoperative hospital services, is based on the preoperative and intraoperative portions of the global payment. Where more than one physician bills for postoperative care, however, the postoperative percentage of the global payment is apportioned according to the number of days each physician was responsible for the patient's care.</p> <p>When postoperative recovery care is split between several physicians, they must agree on the transfer of care. The agreement may be a letter or an annotation in the discharge summary, hospital record, or ambulatory surgical center (ASC) record. The physician assuming the patient's care reports the appropriate procedure code with modifier 55 but may not report any services included in the global period until at least one service has been provided. If the surgeon relinquishes care at the time of discharge, only the date of surgery needs to be indicated when billing with modifier 54. However, if the surgeon provides care after the patient is discharged, it is also necessary to show date of surgery, date of discharge, and date on which postoperative care is relinquished to another physician.</p> <p>When a physician other than the surgeon provides occasional postoperative services during the global period, separate payment is allowed. These services should be reported with the appropriate E/M codes. Physicians should be code for services provided and take particular care using correct ICD-9-CM codes.</p>

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				<p>Payment is not included in the global fee as long as these services are occasional and unusual and do not reflect a pattern of postoperative care. However, separate payment is not allowed if the physician is the covering physician (eg, locum tenens) or part of the same group as the surgeon who performed the procedure and provided most of the postoperative care included in the global package.</p>
<p>Modifier 56: Preoperative Management Only</p>	<p>Description: When 1 physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.</p>		<p>Guideline</p> <ul style="list-style-type: none"> • CPT surgery guidelines: surgical procedures include the operation and the following: <ul style="list-style-type: none"> – Local infiltration; metacarpal, metatarsal, or digital block; topical anesthesia – One related E/M encounter on the day before or day of procedure, after deciding to do surgery – Immediate postoperative care – Writing orders – Postanesthesia recovery evaluation – Typical postoperative follow-up care • CMS and many third-party payers define global physician services as the following: <ul style="list-style-type: none"> – Preoperative management – Surgical procedure – Postoperative management • Guidelines state that subsequent to the decision for surgery, one related E/M encounter on the date 	<p>Used when more than one physician provides services that are part of a global surgery package.</p> <p>CMS policy allows a physician who assumes postsurgical responsibilities for a patient during the hospital stay to report subsequent hospital visits in addition to the postsurgery portion of the global fee. Physicians assuming postsurgical responsibility should report appropriate subsequent hospital care codes for the inpatient hospital care and the surgical code with modifier 55 for the postdischarge care. The surgeon reports the appropriate surgery code with modifier 54.</p> <p>The surgeon's payment, which includes preoperative, intraoperative, and postoperative hospital services, is based on the preoperative and intraoperative portions of the global payment. Where more than one physician bills for postoperative care, however, the postoperative percentage of the global payment is apportioned according to the number of days each physician was responsible for the patient's care.</p>

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			<p>immediately prior to or on the date of the procedure (including history and physical) is included in the surgical package</p>	<p>When postoperative recovery care is split between several physicians, they must agree on the transfer of care. The agreement may be a letter or an annotation in the discharge summary, hospital record, or ambulatory surgical center (ASC) record. The physician assuming the patient's care reports the appropriate procedure code with modifier 55 but may not report any services included in the global period until at least one service has been provided. If the surgeon relinquishes care at the time of discharge, only the date of surgery needs to be indicated when billing with modifier 54. However, if the surgeon provides care after the patient is discharged, it is also necessary to show date of surgery, date of discharge, and date on which postoperative care is relinquished to another physician.</p> <p>When a physician other than the surgeon provides occasional postoperative services during the global period, separate payment is allowed. These services should be reported with the appropriate E/M codes. Physicians should report services provided and take particular care using correct ICD-9-CM codes. Payment is not included in the global fee as long as these services are occasional and unusual and do not reflect a pattern of postoperative care. However, separate payment is not allowed if the physician is the covering physician (eg, locum tenens) or part of the same group as the surgeon who performed the procedure and provided most of the postoperative care included in the global</p>

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Modifier 57: Decision for Surgery	<p>Description: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.:</p>		<p>Guideline</p> <ul style="list-style-type: none"> • Used when E/M service results in initial decision to perform a surgical procedure • Allows separate payment for that visit at which the decision to perform the surgery was made <ul style="list-style-type: none"> – If adequate documentation is available demonstrating that the decision for surgery was made during a specific visit 	<p>package.</p> <p>Use of modifier 57 is limited to operations with 90-day global periods. Modifier 57 allows separate payment for the visit at which the decisions to perform the surgery was made if adequate documentation is submitted demonstrating that the decision for surgery was made during a specific visit</p> <ul style="list-style-type: none"> • Append to an E/M code only when that E/M service represents the initial decision to perform a major surgical procedure • Do not use with E/M visits during the 0–10 day global period for minor procedures unless the visit is to decide about major surgery • Separate documentation not required with claim submission
Modifier 58: Staged or Related Procedure or Service by the Same Physician During the Postoperative Period	<p>Description: 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/procedure room (eg, unanticipated clinical condition),</p>		<p>Guideline</p> <ul style="list-style-type: none"> • Revised in 2008 <ul style="list-style-type: none"> – Eliminated “planned prospectively” – Added language “planned or anticipated during the postoperative period” • This modifier is used to report a staged or related procedure by same physician during the postoperative period of the first procedure <ul style="list-style-type: none"> – At times, it may become necessary for a surgeon to perform one procedure and then, during the postoperative period associated with the original procedure, perform a procedure that is “staged” or related • Modifier 58 is appended to the procedure code for a second procedure that falls into one of three categories: 	<p>This modifier is not used to report the treatment of a problem that requires a return to the operating room. If a diagnostic biopsy precedes the major surgery performed on the same day or in the postoperative period of the biopsy, modifier 58 should be reported with the major surgical procedure code, for which full payment is allowed (eg, mastectomy within 10 days of a needle biopsy). Additionally, if a less extensive procedure fails and a more extensive procedure is required, the second procedure should be reported with modifier 58. If the less extensive procedure and the more extensive procedure are performed as staged procedures, the second procedure should be reported with modifier 58.</p>

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	see modifier 78.		<ul style="list-style-type: none"> – Planned or anticipated at the time of the original procedure (staged) – More extensive than the original procedure – Therapy following a diagnostic surgical procedure • Use only during the global surgical period for the original procedure 	<ul style="list-style-type: none"> • Not used to report treatment requiring return to the operating room • For diagnostic biopsy preceding major surgery on same day or in postoperative period of the biopsy, report modifier 58 with surgery code – Full payment allowed • For more extensive procedure required by failure of lesser procedure, report modifier 58 with more extensive procedure • For less extensive and more extensive procedures performed as staged procedures, report modifier 58 with second procedure <p>The National Correct Coding Initiative and Modifier 58</p> <ul style="list-style-type: none"> • If a procedure is planned or anticipated, because it was more extensive than the original or because it represents therapy: <ul style="list-style-type: none"> – Modifier 58 may be appended to the second procedure during the postoperative period • When an endoscopic procedure is performed for diagnostic purposes at the time of a therapeutic procedure, and the endoscopic procedure does not represent “scout” endoscopy: <ul style="list-style-type: none"> – Modifier 58 may be appropriately used to signify that the endoscopic procedure and the more comprehensive therapeutic procedure are staged or planned procedures
Modifier 59: Distinct Procedural Service	<p>Description: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from</p>		<p>Guideline</p> <ul style="list-style-type: none"> • Used to identify procedures or services that are not normally reported together, but are appropriate under the circumstances – Should be used only if no more descriptive modifier is 	<p>NCCI Guidelines</p> <ul style="list-style-type: none"> • Modifier 59: <ul style="list-style-type: none"> – Was established for use when several procedures are performed on different

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	<p>other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.</p>		<p>available, and the use of modifier 59 best explains the circumstances</p> <ul style="list-style-type: none"> • This modifier underwent revision in 2008 <ul style="list-style-type: none"> – Language of “physician” in its descriptor along with language indicating that documentation must support a different session instead of “patient encounter” <p>Separate Procedure</p> <ul style="list-style-type: none"> • Some of the procedures or services listed in the CPT nomenclature that are commonly carried out as an integral component of a total service or procedure have been identified by including the term “separate procedure” • Codes designated as separate procedures should not be reported in addition to the code for the total procedure or service of which it is considered an integral component • Examples of CPT codes with “separate procedure” in the code description <ul style="list-style-type: none"> • 29870—Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure) • 38780—Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure) • 44312—Revision of ileostomy; simple (release of superficial scar) (separate procedure) 	<p>anatomical sites, or at different sessions (on the same day)</p> <ul style="list-style-type: none"> – Indicates that the procedure represents a distinct service from others reported on the same date of service – Is appended when distinct and separate multiple services are provided to a patient on a single date of service – Was developed explicitly for the purpose of identifying services not typically performed together • Assigned modifier indicators in the National Correct Coding Initiative (NCCI) <ul style="list-style-type: none"> – “0” An NCCI-associated modifier cannot be used to bypass the edit – “1” An NCCI-associated modifier may be used to bypass the edit if it meets the criteria under appropriate circumstances – “9” Edit deleted on the same date as when it became effective <p>CMS Guidelines for Using Modifier 59 With the Medicine Section</p> <ul style="list-style-type: none"> • Chemotherapy administration codes: for administration by multiple routes <ul style="list-style-type: none"> – Separate payment is allowed for chemotherapy administration by push and by infusion technique on the same day, but only one push administration is allowed on a single day – It is recognized that combination chemotherapy is frequently provided by different routes at the same session – Modifier 59 can be appropriately used when two different modes of chemotherapy administration

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				<p>are used</p> <p>CMS Guidelines for Using Modifier 59 With the Medicine Section</p> <ul style="list-style-type: none"> • Fluid administration only to maintain patency of the access device, the infusion is neither diagnostic nor therapeutic. <ul style="list-style-type: none"> – Injection, infusion, or chemotherapy administration codes are not to be separately reported – In the case of transfusion of blood or blood products, the insertion of a peripheral intravenous line is routinely necessary and not separately reported – Administration of fluid in the course of transfusions to maintain line patency or between units of blood products is not to be separately reported – If fluid administration is medically necessary for therapeutic reasons in the course of a transfusion or chemotherapy, this could be separately reported with the modifier 59 • Biofeedback services involving electromyographic techniques <ul style="list-style-type: none"> – CPT codes 95860-95874 (electromyography) should not be reported with biofeedback services based on the use of electromyography during a biofeedback session – If an electromyogram is performed as a separate medically necessary service for diagnosis or follow-up of organic muscle dysfunction, the appropriate electromyography codes may be reported – Modifier 59 should be added to indicate that

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				<p>the service performed was a separately identifiable diagnostic service</p> <ul style="list-style-type: none"> • Pulmonary stress testing <ul style="list-style-type: none"> – For a standard exercise protocol, serial electrocardiograms, and a separate report describing a cardiac stress test (professional component), cardiac and pulmonary stress tests could be reported – Modifier 59 should be reported with the secondary procedure
<p>Modifier 62: Two Surgeons</p>	<p>Description: 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) during the same surgical session, those services</p>		<p>Guideline To code a surgery that involves multiple surgeons, it is necessary to have all the operative reports of all the surgeons involved in a particular case wherein the physicians each provided distinct services, with all these services being related to one surgery. Each surgeon should report the individual procedure(s) he/she performs related to the definitive surgery indicating two surgeons have performed the work included in one total procedure, reportable with a single code. Each surgeon should report the same distinct procedural code with the modifier 62 appended. In separate operative reports, both physicians would document their level of involvement in the surgery. Each should include a copy of the notes when reporting the service to the third-party payer. If one surgeon does not use the modifier 62, the third-party payer may assume that the physician reporting the procedure without the modifier performed the entire procedure, despite the second physician reporting the procedure with the modifier 62.</p> <p>The guidelines for use of modifier 62 denote the circumstance in which an additional surgeon for a specific surgery acts not as an assistant at surgery, but</p>	<p>Cosurgery may be required because of the complexity of the procedure(s), the patient's condition, or both. The additional surgeon(s) is not acting as an assistant at surgery in these circumstances. Payment is based on 125% of the global amount, which is divided equally between two surgeons. Documentation to establish medical necessity for both surgeons is required for some services.</p> <p>CMS Guidelines for Using Modifier 62 With the Radiology Section</p> <ul style="list-style-type: none"> • Medicare Fee Schedule Database (MFSDB) indicators <ul style="list-style-type: none"> – MFSDB indicator 1, procedures with modifier 62 paid when documentation submitted with claim – MFSDB indicator 2, procedures with modifier 62 paid without documentation submitted with the claim – MFSDB indicator 0 or 9, procedures may not be billed as co-surgery

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Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
	<p>may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.</p>		<p>actually performs a distinct portion of the procedure in the capacity of a co-surgeon, or second primary surgeon. The use of the modifier 62 allows for greater versatility in reporting the services provided by each surgeon. From a CPT coding perspective, the use of the modifier 62 is not limited to those procedures performed by physicians of differing specialties.</p>	<p>CMS and Modifier 62</p> <ul style="list-style-type: none"> • Modifier 62 may be billed when two or more surgeons of same specialty perform <ul style="list-style-type: none"> – Parts of one procedure – The same or similar procedures in separate body areas – Components of a related procedure or procedures generally performed by the same surgeon – One procedure or components of related procedures performed by two or more surgeons of different specialties • Co-surgeon reimbursement only for procedure codes designated as eligible for modifier 62 • For co-surgeons, the fee schedule amount applicable to the payment for each cosurgeon is 62.5% of the global surgery fee schedule amount based on the MFSDB • Surgeons of different specialties each performing different procedure with specific CPT codes <ul style="list-style-type: none"> • Neither co-surgery nor multiple surgery rules apply even if the procedure(s) are performed through the same incision • If one performs multiple procedures <ul style="list-style-type: none"> • Multiple procedure rules apply to that surgeon's services
<p>Modifier 63: Procedure Performed on Infants Less Than 4 kg</p>	<p>Description: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these</p>		<p>Guideline:</p> <ul style="list-style-type: none"> • Appended only to invasive surgical procedures • Reported only for neonates or infants up to a present body weight of 4 kg • Significant increased work intensity related to <ul style="list-style-type: none"> – Temperature control – Obtaining and maintaining intravenous access 	<p>The procedures with which modifier 63 cannot be reported are generally procedures performed on infants for the correction of congenital abnormalities and are exempt from appending the modifier 63. It is not appropriate to report the modifier 63 because the additional work that the modifier 63 is intended to</p>

Attachment C - Modifiers

Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
	<p>patients. This circumstance may be reported by adding modifier 63 to the procedure number.</p> <p>Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20005- 69990 code series. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections.</p>		<ul style="list-style-type: none"> – The operation itself, which is technically more difficult with regard to maintenance of homeostasis • Not for use with procedures for the correction of congenital abnormalities • Not for use with procedures that include pediatric status in descriptors • Examples of appropriate modifier 63 use <ul style="list-style-type: none"> – 33820 Repair of patent ductus arteriosus; by ligation – 44120 Enterectomy, resection of small intestine; single resection and anastomosis – 44140 Colectomy, partial; with anastomosis – 43220 Esophagoscopy, rigid or flexible; with balloon dilation • Not for use with procedures for the correction of congenital abnormalities • Not for use with procedures that include pediatric status in descriptors 	<p>represent has been previously identified as an inherent element within the procedures in this list. When appended to a procedure, the modifier 63 indicates the additional difficulty of performing a procedure, which may involve significantly increased complexity and physician work commonly associated with neonates and infants up to a body weight of 4 kg.</p>
<p>Modifier 66: Surgical Team</p>	<p>Description: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the “surgical team” concept. Such circumstances may be identified by each participating physician with the addition of modifier 66 to the basic procedure number used for reporting services.</p>		<p>Guideline In certain CPT codes, one major procedure is listed without indicating the various components of that service that combines the work of several physicians and other specially trained personnel. If additional services are provided by any of the physicians on the surgical team, this should be indicated in a specific operative note. If one surgeon assists another surgeon with a procedure, then modifiers 80, Assistant Surgeon, 81, Minimum Assistant Surgeon, or 82, Assistant Surgeon (when qualified resident surgeon not available) may be more appropriate to report than modifier 66.</p> <p>Under some circumstances, highly complex procedures</p>	<p>Team surgery may be required because of the complexity of the procedure(s), the patient’s condition, or both. The additional surgeon(s) is not acting as an assistant at surgery in these circumstances. Team surgery involves a single procedure (reported as a single procedure code) that requires more than two surgeons of different specialties and is reported by each surgeon (with the same procedure code) with modifier 66. Payment amounts are determined by carrier medical directors (CMDs) on individual basis.</p> <ul style="list-style-type: none"> • Section 15046 of the Medicare Carriers’ Manual

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Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
			<p>(requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of the modifier 66 to the basic procedure number used for reporting services.</p>	<ul style="list-style-type: none"> • Complex medical procedures <ul style="list-style-type: none"> – Require more than two surgeons of different specialties – Each physician performs a unique function requiring special skills integral to the total procedure – Each engaged in a level of activity different from assisting the surgeon in charge of the case • Reimbursement for team physicians <ul style="list-style-type: none"> – Based on general reasonable charge criteria consistent with reimbursement practices in the service area – Amounts determined by carrier medical directors on an individual basis – Reported by each surgeon with same procedure code and modifier 66 – “By-report” basis: report with chart and operative notes must be submitted with claim • Physicians should determine procedures that require team approach <ul style="list-style-type: none"> – Complex procedures – Multiple medical conditions of one patient
<p>Modifier 76: Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional</p>	<p>Description: 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.</p>		<p>Guideline</p> <ul style="list-style-type: none"> • Modifier 76 is intended to describe the same procedure or service repeated, rather than the same procedure being performed at multiple sites 	<ul style="list-style-type: none"> • Use of modifier 76 appropriate <ul style="list-style-type: none"> – Procedure performed in an operating room or place equipped specifically for procedures – Medical necessity evident – Identical services performed • Examples <ul style="list-style-type: none"> – Follow-up X rays – Repeated electrocardiograms – Repeated coronary angiogram or coronary artery bypass

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Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
Modifier 77: Repeat Procedure by Another Physician or Other Qualified Health Care Professional	<p>Description: 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.</p>		<p>Guideline</p> <ul style="list-style-type: none"> • Modifier 77 is used when a procedure is repeated by a different physician than the original physician 	<ul style="list-style-type: none"> • CMS recognizes the use of modifier 77 <ul style="list-style-type: none"> – Medical necessity of repeated procedure must be evident • Modifier 77 used <ul style="list-style-type: none"> – When another physician repeats a procedure or service on the same day – For multiple diagnostic tests performed on the same day
Modifier 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	<p>Description: 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.)</p>		<p>Guideline</p> <ul style="list-style-type: none"> • Title and definition revised to distinguish this modifier from modifier 58 • Modifier 78 and 58 were previously used interchangeably due to inadequate distinction between them • Unplanned included in title indicates that Modifier 78 is reserved for unplanned/not foreseen in advance procedures • Title revised to indicate that Modifier 78 applies to unplanned procedure performed by the same physician rendering the initial procedure to provide consistency with the intent of modifier 78. • Term Operating Room expanded to include procedure room to avoid limiting this code to inpatient procedures • “On the same day” deleted. 	<p>Payment for reoperations is made only for the intraoperative and postoperative care because CMS considers these services to be part of the original global surgery package. The approved amount will be set at the value of the intraoperative service the surgeon performed when an appropriate CPT code exists (eg, 32120, Thoracotomy, major; for postoperative complications). However, if not CPT code exists to describe the specific reoperation, the appropriate unlisted procedures code from the surgery section of CPT would be used. Payment in these cases is based on up to 50% of the value of the intraoperative service that was originally provided.</p> <ul style="list-style-type: none"> • For related procedure performed on the same day or during a global period of more than 0 days • Used to indicate that a subsequent procedure

Attachment C - Modifiers

Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
				<p>related to the initial procedure was performed during the postoperative period of the initial procedure</p> <ul style="list-style-type: none"> • Should be reported when complications arising from the surgery require use of the operating room • To be considered a complication, operating room must be required • When reporting a procedure with modifier 78: <ul style="list-style-type: none"> - A new global period does not begin - Carrier will pay the value of the intraoperative service of the code that describes the treatment of the complication(s) • For procedure with "0" global period reported with modifier 78 <ul style="list-style-type: none"> - Carriers pay the full value for the procedure • If the patient is returned to the operating room after the initial operative session, but on the same day as the original surgery for one or multiple procedures: <ul style="list-style-type: none"> - Append modifier 78 to each procedure code for treatment of complication(s) - Multiple surgery rules do not apply • If the patient is returned to the operating room during the postoperative period of the original surgery, but not on the same day of the original procedure, and bilateral procedures are required as a result of the complication from the original surgery: <ul style="list-style-type: none"> - Complication rules apply - Multiple surgery rules do not apply • For return to operating room during postoperative period but not on the same day, and bilateral procedures required to treat

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Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
Modifier 79: Unrelated Procedure or Service by the Same Physician During the Postoperative Period	Description: The physician 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.)		Guideline <ul style="list-style-type: none"> • Indicates that the operating surgeon performed a procedure on a surgical patient during the postoperative period for problems unrelated to the original surgical procedure • The procedure <ul style="list-style-type: none"> – Must be performed by the same physician – Reported by appending modifier 79 to the procedure code 	complication of original surgery <ul style="list-style-type: none"> – Complication rules apply – Bilateral surgery rules do not apply Separate payment for the unrelated procedure is allowed under these circumstances and is reported by appending modifier 79 to the procedure code. Modifier 79 is used to report, for example, an appendectomy performed during the global period of a mastectomy by the same surgeon. <ul style="list-style-type: none"> • Shows a second procedure by the same physician (or physician of the same specialty in the same surgical group) was unrelated to previous procedure for which the postoperative period has not been completed • Documentation, such as different diagnosis (ICD-9-CM), usually sufficient • Does not mandate a return to the operating room and not limited to surgical procedures • Reimbursed at 100% of the allowable amount
Modifier 80: Assistant Surgeon	Description: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).		Guideline <ul style="list-style-type: none"> • One physician assists another in a procedure • Assistant surgeon who assists a primary surgeon for entire operation or substantial portion of it <ul style="list-style-type: none"> – Reports the same surgical procedure as the operating surgeon – Reports the same CPT code as the operating physician, with modifier 80 appended – Operating surgeon does not append a modifier to the procedure reported 	<ul style="list-style-type: none"> • The assistant surgeon <ul style="list-style-type: none"> – Must actively assist when a physician performs a Medicare-covered surgical procedure – Must be involved in the actual performance of the procedure, not simply provide ancillary services – Would not be available to perform another surgical procedure during the same time • Current law requires <ul style="list-style-type: none"> – Approved amount for assistant surgeons be set at the lower of the actual charge or 16% of the global surgical approved amount – Payment for services of assistant surgeons be made only when most recent

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Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
				<p>national Medicare claims data indicate a procedure has used assistants in at least 5% of cases based on a national average percentage</p> <ul style="list-style-type: none"> • Full payment for assistant surgeon's services may be made for some procedures if documentation is provided establishing medical necessity • Physician not participating in the Medicare program <ul style="list-style-type: none"> – Limiting charge is 115% of 16% of the nonparticipating fee schedule amount • For assistant-at-surgery with state licensure permitting this role for limited-license practitioner <ul style="list-style-type: none"> – Payment is 10.4% of the fee schedule amount for the particular surgery • Database indicators for modifier 80 approval <ul style="list-style-type: none"> – 0 Procedure requires medical necessity documentation for Medicare payment – 1 Procedures not payable under Medicare Fee Schedule – 2 Procedure allows payment for assistant-at-surgery with modifier 80 – 9 Assistant surgery concept does not apply • Appropriate assistant surgeon modifier (80 or AS) must be submitted with surgical code(s) when billing for assistant-at-surgery • Medicare <ul style="list-style-type: none"> – Reimburses only if medical necessity is documented – Does not pay for an assistant when there is an assistant-at-surgery restriction – Reimburses for an assistant surgeon (MD,

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Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
				PA, NP, or CNS) • Claims from an assistant-at-surgery – Subject to the same edits applied to claims from a primary surgeon or other physician providing care during the global period of a procedure • All claims for second assistant must have an operative report attached – Lack of documentation to support the medical necessity for an assistant-at-surgery will cause denial of payment for the service
Modifier 81: Minimum Assistant Surgeon	Description: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.		Guideline • Assistant surgeon services required for a relatively short time – Second surgeon provides minimal assistance – Second surgeon reports the surgical procedure code with modifier 81	• Rarely recognizes modifier 81 • For modifier 81 with procedure code with a maximum allowable payment – Maximum allowable payment will be no more than 13% of that in the CMS rules or the billed charge, whichever is less • For modifier 81 with a by-report procedure – Maximum allowable payment for the procedure will be no more than 13% of the reasonable amount for the primary procedure
Modifier 82: Assistant Surgeon (When Qualified Resident Surgeon Not Available)	Description: The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).		Guideline • Assistant surgeon is usually a qualified resident surgeon • Another surgeon may assist in surgery when qualified resident surgeon not available – Nonresident assistant surgeon services reported with modifier 82 appended to procedure code	• Payment not made for assistants-at-surgery services in teaching hospital with training program related to the required specialty and qualified resident available – Unless exceptional medical circumstances exist • If the procedure is deemed ineligible – Cost cannot be passed on to the patient Exceptional Medical Circumstances • Payment is made for the services of

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Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
				assistants-at-surgery in teaching hospitals in the following circumstances: – Emergency or life-threatening situations in which multiple traumatic injuries require immediate treatment – Primary surgeon has an across-the-board policy of never involving residents in perioperative care of his or her patients Assistant-at-Surgery Modifiers • 80: For nonteaching settings or teaching settings with resident available but not used by surgeon • 82: Qualified resident surgeon not available; used in teaching hospitals without approved training relevant program or no qualified resident available • AS: Services performed by a PA or NP
Modifier 90: Reference (Outside) Laboratory	Description: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.		Guideline Used by a physician or clinic when laboratory tests for a patient are performed by an outside or reference laboratory	• CMS does not recognize the use of modifier 90 • Physicians should not bill Medicare or Medicaid recipients for laboratory work done outside the office • Physicians may bill insurance carriers only for laboratory testing performed in the office
Modifier 91: Repeat Clinical Diagnostic Test	Description: In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91.		Guideline • Modifier 91 – Appended to laboratory code to indicate repetition of a laboratory test on same day for same patient as part of treatment – May not be used when other code(s) describe a series of test results – Would be reported only when laboratory tests are performed more than once during the same day for the same patient Modifier 59 vs Modifier 91	• To be covered by Medicare, the repeat diagnostic laboratory test must be rendered the same day, the same test as originally rendered, and for the same patient – If the above criteria are fulfilled, the repeat test may be billed with modifier 91 appended

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Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
	<p>Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.</p>		<ul style="list-style-type: none"> • Modifier 59: <ul style="list-style-type: none"> – added to report instances when distinct and separate multiple services provided to a patient on a single date of service – used to report procedures that are distinct or independent, such as performing the same procedure for a different specimen • Modifier 91 <ul style="list-style-type: none"> – Intended to identify a laboratory test that is performed more than once on the same day for the same patient, when it is necessary to obtain subsequent (multiple) results in the course of the treatment – Not intended for use when there are CPT codes available to describe the series of results 	
<p>Modifier 92: Alternative Laboratory Platform Testing</p>	<p>Description: When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701-86703, and 87389). The test does not require permanent dedicated space, hence by its design may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this</p>		<p>Guideline</p> <ul style="list-style-type: none"> • Modifier 92 added in 2008 • Identifies laboratory testing using a kit or transportable instrument for single use, with disposable analytic chamber <ul style="list-style-type: none"> – Portable – Can be hand carried or transported to the patient for immediate testing • Applicable only to the following <ul style="list-style-type: none"> – 86701 Antibody; HIV-1 – 86702 Antibody; HIV-2 – 86703 Antibody; HIV-1 and HIV-2, single assay 	<p>When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIC testing 86701-86703). The test does not require permanent dedicated space, hence by its design may be hand carried or transported to the vicinity of the patient for immediate testing at the site, although location of the testing not itself determinative of the use of this modifier.</p>

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Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
Modifier 99: Multiple Modifiers	<p>modifier.</p> <p>Description: Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.</p>		<p>Guideline</p> <ul style="list-style-type: none"> • Under certain circumstances two or more modifiers may be necessary to completely delineate a service <ul style="list-style-type: none"> – Modifier 99 should be added to the basic procedure – Other applicable modifiers may be listed as part of the description of the service 	<ul style="list-style-type: none"> • Modifier 99 informational only for CMS and alerts carrier that additional modifiers are to follow

Attachment D

RBRVS versus Medicare or other Fee Schedule

In a resource-based relative value scale (RBRVS) system, payments for services are determined by the resource costs needed to provide them. The cost of providing each service is divided into three components: physician work, practice expense and professional liability insurance. This is merely an allocation system to fairly represent the above three components across all services performed.

- The physician work component accounts, on average, for 48 percent of the total relative value for each service.
- The practice expense component of the RBRVS accounts for an average of 48 percent of the total relative value for each service.
- Centers for Medicare and Medicaid the Services (CMS) assigned professional liability insurance component of the RBRVS accounts for an average of 4 percent of the total relative value for each service.

Payer payments are then calculated by multiplying the combined costs of a service by a conversion factor (a monetary amount that is determined by CMS). CMS has an established pool of dollars that can be spent, therefore the conversion factor is a reflection of the budget for the current year. Medicare also allows an adjustment for geographical differences in resource costs. Payments can also be adjusted for geographical differences in resource costs by using the GPCI. The conversion factor and GPCI are calculated independent of the RBRVS system.

The percentages assigned to the modifiers and the methodology and percentages assigned to the multiple procedure reduction methodology are assigned by CMS, but originally were based solely on the RBRVS and the cost of providing each service and was independent of budget restrictions or political pressures. There have been recent exceptions to that rule, which includes the CMS radiology reductions that were not based on the RBRVS system.

Visit www.ama-assn.org/go/rbrvs for more information regarding the RBRVS system.

Pricing definition and guidelines

“Pricing rules” globally are defined to mean payment rules applied by a health plan or its agent to increase or decrease the agreed fee schedule amount (but not decreased to \$0) in specified circumstances.

Pricing rules considered in scope for discussion are contained within the CO legislation (Bill HB10_1332), such as when several procedures are done at the same time (multiple procedure reduction logic), the designated bilateral procedure is done on both sides of the body (bilateral modifier payment percentage), the service is provided by an assistant surgeon (assistant at surgery payment percentage), services are included within a global period or global procedure, etc. View the CO legislation for a full listing of procedures.

Recommendation for consensus

Pricing rule definition is approved as defined above.

Payment rule guidelines

- The purpose of pricing rules is to move toward a uniform, transparent practice in the marketplace.
- The Medicare pricing rules based on the RBRVS are recommended for the starting point of the discussion for the development of a national payment rule standard because they are already widely used by both public and private payers and maintain the relativity of the Medicare RBRVS.
- Pricing rules should not include cost containment, political influences or benefit limitations.
- The pricing rules must not affect payers' ability to negotiate and agree upon contracted rates with physicians and other health care providers for the performance of medical procedures and services.
- The pricing rules only standardize the way payment rules are applied to those negotiated fee-schedules.

Recommendation for consensus

- I. Pricing rule guidelines are approved as listed above.**
- II. Rules work group is charged with bringing forward pricing rule recommendations that meet the above stated guidelines and legislation requirements.**

Modifier definition

A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities. Documentation of special circumstances is sometimes required by the payer to receive full reimbursement on the claim, but guidelines vary from payer to payer.

Recommendation for consensus

Modifier definition is approved as defined above.

Attachment E

HB 10-1332 Medical Clean Claims and Uniform Act Task Force



Report to the Colorado General Assembly and
Department of Health Care Policy and Financing

(Report due November 30, 2012)

Outline: Draft 2 (9-14-12)

Letter of Transmittal

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Executive Summary

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I. Purpose of report (brief)

- A. Responds to direction in HB 10-1332 to report progress on and recommendations concerning:
 - 1. Development of a base and complete set of edits and payment rules
 - 2. Establishment and operation of a data system repository
 - 3. Schedule for commercial plans to implement set

Legislation and Clean Claims Task Force

II. Legislation

- A. Problem addressed by HB-10-1332 and Goals of HB 10-1332
- B. Legislation and legislative charge (including major elements of legislation, applicability, charge, what law doesn't cover, enforcement, statutory deadlines, etc.)
- C. Model for the country and related developments (e.g., note Affordable Care Act provision, Medicaid and Medicare now using same code editing system, etc.)

III. Task Force

- A. Task force members and how appointed
- B. Task force process (e.g., consensus process, guiding principles, committees, top stakeholder concerns, etc.)
- C. Funding and staffing
- D. Overview of task force accomplishments

Progress Report and Recommendations

IV. Base and complete set of rules

- A. Background
- B. Process (edit and payment rules committees, steps to get to standardized set, RFI and RFP etc.)
- C. Issues, challenges, unanticipated developments and task force responses.
 - Examples of issues, challenges, unanticipated developments: can't separate basic and comprehensive standard set edits; national initiative did not proceed with creating a standardized edit set; in-scope and out-of-scope edits needed to be further refined;
- D. Progress report
- E. Recommendations

V. Data system repository

- A. Background--Legislation asks for recommendations regarding implementation, updating and dissemination of the standard set, including who is responsible for establishing a central repository for accessing rules and edits and enabling electronic access—including downloading capability—to the rules set. Two main issues: Who operates, makes accessible and disseminates? Who establishes, governs and makes policy decisions? Task force also addressed sustainability.
- B. Process (e.g., committee, guiding principles, steps in process)
- C. Issues, challenges, unanticipated developments and task force response
 - Examples of issues: breadth of DSR responsibilities (e.g., handle complaints? respond to requests for changes to the edit set?)
- D. Progress report (e.g., issued RFI and RFP; decided on business model; developed list of funding options, etc.)
- E. Recommendations (e.g., DSR functionalities; business model; what is not part of the DSR (e.g., claims auditing); who operates, makes accessible and disseminates; who implements; how are updates done and edits added, deleted or modified; what is governance structure?)

VI. Schedule for commercial plans to implement the standardized set

- A. Background
- B. Process [OMIT?]
- C. Challenges, unanticipated developments and task force response
- D. Progress report
- E. Recommendations

Next Steps

VII. Work plan and deliverables for 2013 and 2014

Figures, Tables, Boxes

(not in any particular order)

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- BB-2 Examples of claim edits
- BB-3 Key terms and acronyms
- BB-4 Affiliations of task force members
- BB-5 Example of problem with current system
- BB-6 Steps in process diagram
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- BB-8 Summary box: status report and recommendations
- BB-9 Steps to get to standardized set
- BB-10 Decision Rule for selecting, adding, deleting, modifying and reconciling conflicting edits
- BB-11 Guiding principles for DSR

Appendices

(not in any particular order)

- AA-1 HB 10-1332
- AA-2 List of task force members
- AA-3 RFI and/or RFP