

HB 10-1332 Colorado Medical Clean Claims Transparency & Uniformity Act Task Force Meeting May 25, 2011

Location: University Physicians, Inc.
13199 East Montview Blvd, Aurora, CO 80045
Lilly Marks Boardroom

Directions from I-25

Take I-25 to I-225 North. Proceed north on I-225 to Colfax Avenue (Exit 10). You will want to be in the right hand, left turn lane, and turn Left (West). At Fitzsimmons Parkway (second light), you will turn Right (North). You will want to be in the Left lane on Fitzsimmons Parkway. Drive approximately half mile (.5 miles) to Montview Boulevard (Not a light, you will see a silver, round metal building on the Northwest corner with an Aurora Police Department Bus). Turn Left (West). ****Watch your speed, it is only 25****. Take Montview Blvd West to Victor Street. Turn North to our Parking Garage. For parking/taxi/shuttle directions, please see below.

Directions from I-70

Take I-70 to I-225 South. Proceed south on I-225 to Colfax Avenue (Exit 10). Turn Right (West). At Fitzsimmons Parkway (first light), you will turn Right (North). You will want to be in the Left lane on Fitzsimmons Parkway. Drive approximately half mile (.5 miles) to Montview Boulevard (Not a light, you will see a silver, round metal building on the Northwest corner with an Aurora Police Department Bus). Turn Left (West). ****Watch your speed, it is only 25****. Take Montview Blvd West to Victor Street. Turn North to our Parking Garage. For parking/taxi/shuttle directions, please see below.

Directions from DIA

Take the ramp onto Pena Blvd. Take exit 282 to merge onto I-225 South, toward Colorado Springs/Aurora. Proceed south on I-225 to Colfax Avenue (Exit 10). Turn Right (West). At Fitzsimmons Parkway (first light), you will turn Right (North). You will want to be in the Left lane on Fitzsimmons Parkway. Drive approximately half mile (.5 miles) to Montview Boulevard (Not a light, you will see a silver, round metal building on the Northwest corner with an Aurora Police Department Bus). Turn Left (West). ****Watch your speed, it is only 25****. Take Montview Blvd West to Victor Street. Turn North to our Parking Garage. For parking/taxi/shuttle directions, please see below.

For Parking

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If you took a Taxi/Shuttle

Please have the taxi, turn onto Victor Street, turn left at driveway, and follow this around to the back of the building. You will go through the doors, pass the elevators, and the Lilly Marks Boardroom will be located on the door on your left.

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

**Two-day meeting: Tuesday, February 26, 2013 (noon - 6 p.m. MST) and
Wednesday, February 27, 2013 (7:30 a.m. - 3 p.m. MST)**

Call-in number: 1-800-866-740-1260, ID 8586328#

Facilitator: Barbara Yondorf, Yondorf & Associates

Agenda

Day 1--Tuesday, February 26, 2013

- | | |
|------------------|---|
| 12 - 12:45 PM | Lunch |
| 12:45 – 12:50 PM | Welcome & Introductions |
| 12:50 – 1:05 PM | Housekeeping <ul style="list-style-type: none">• Approve February 2013 meeting minutes (Attachments A-1 & A-2)
Discuss use of Executive Summary• Review of agenda• Meeting procedures• Thanks to Anthem and the Colorado Medical Society for sponsoring the catering for 2/26 and 2/27. |

Committee Reports

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

- | | |
|------------------|---|
| 1:10 – 1:30 p.m. | Payment Rules Committee—Lisa Lipinski |
| 1:30 – 1:40 p.m. | Specialty Society—Tammy Banks/Helen Campbell |
| 1:40 – 3:00 p.m. | Edit Committee <ul style="list-style-type: none">• CONSENSUS ITEM: Modifier Table (Attachments B-1 and B-2)• Specifications document (Attachment C) |
| 3:00 – 3:15 p.m. | Break |
| 3:15 – 4:30 p.m. | Data Sustaining Repository – Mark Rieger/Val Clark <ul style="list-style-type: none">• CONSENSUS ITEM: Amendments to Edit/Rule Development and Adoption Process (Attachment D) |
| 4:30 – 5:30 p.m. | Refreshments and DSR Consensus Item Discussion (cont'd) |
| 5:30 p.m. | Adjourn for the Day |

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

Wednesday, February 27, 2013 (7:30 a.m. - 3 p.m. MST)

Call-in number: 1-800-866-740-1260, ID 8586328#

Facilitator: Barbara Yondorf, Yondorf & Associates

Agenda

Day 2—February 27, 2013

- | | |
|------------------|---|
| 7:30 - 8:00 AM | Continental Breakfast |
| 8:00 – 8:20 AM | Program Management and Finance – Barry Keene
Legislative update – SB 13-166 |
| 8:20 – 10:00 AM | Applying the Process for Developing and Adopting a Standard Edit <ul style="list-style-type: none">• Test case: assistant-at-surgery as a test case—Marilyn Rissmiller, Mark Rieger and Barbara Yondorf (Attachments E and F)• Revisit decision rule as necessary based on test case lessons |
| 10:00 - 10:15 AM | Break |
| 10:15 - 11:45 AM | Applying the Process (cont'd) |
| 11:45 - 12:15 PM | Lunch |
| 12:15 - 1:30 PM | Review Task Force Work Plan for 2013-2014
Committee chairs discussion |
| 1:30 – 1:50 PM | Other Business <ul style="list-style-type: none">• Future Meeting Schedule (Attachment G)• RFP status update |
| 1:50 PM | Public Comment |
| 2:00 PM | ADJOURNMENT |

DRAFT

HB10_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT TASK FORCE

Meeting Minutes

January 23, 2013, noon-2 PM, MST

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

Conference ID: ID 8586314

Attendees:

- Amy Hodges
- Barry Keene, CC
- Beth Provost
- Beth Wright
- Dee Cole
- Doug Moeller, MD
- James Borgstede, MD
- Jill Roberson
- Kathy McCreary
- Kim Davis
- Mark Painter
- Mark Rieger
- Marilyn Rissmiller, CC
- Robin Weston
- Tom Darr, MD
- Valerie Clark
- Lisa Lipinski

Staff :

- Connor Holzkamp
- Barbara Yondorf

Public:

- Diane Hayak (ACR)
- Jenny Jackson (ACS)
- Pam Kassing, (ACR)
- Beth Kujawski (UPI)

Meeting Objective (s):

Key:

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

Parking Lot:



January 23, 2013

DISCUSSION

ROLL CALL & WELCOME:

There were 17 Task force Members in attendance

Marilyn: First order to approve December minutes. Any changes? Hearing none do I have a motion to approve?

Beth made motion and Doug seconded motion.

December minutes approved with no changes

Marilyn: Barry you are first up on the Agenda with the report on how the testimony went to the legislature on the 10th of January.

REPORT TO THE LEGISLATURE- BERRY KEENE

Barry: Our report was well received by the legislature. Marilyn and I both testified, and there were several other task force members there as well so we appreciate that. There were some good questions that were posed to us, and generally the questions were in a very positive direction. Senate Bill 659 is operative now to extend our timeline as was discussed in one of our recommendations. Senator Irene Aguilar, who is a practicing physician and the chair of the Senate Health and Human Services Committee, has written a letter on our behalf to the foundations encouraging that they would continue to support us, as well as a letter to the Secretary of Health and Human Services that was parallel to the letter that Sue Birch has penned to the Secretary of Health and Human Services regarding another one of our recommendations. As kind of a bonus of that exercise, this Senate Bill 659 is carrying with it a lifting of the prohibition for the DHCPF to appropriate money to us. Now that doesn't say that there is any money, it is just lifting the prohibition meaning if I *can* manage to leverage some money through the legislature and through appropriations they would be allowed to have it go to our fiscal sponsor to support our activities. This was actually something that was offered to us by Senator Aguilar to make things a little bit easier to manage if we can find some appropriated moneys. So overall we do expect this bill to go through and it seemed to have good bipartisan support from what I could tell from the committee. It certainly had stout bipartisan support originally and we do not believe that has eroded at all. So that's all I had to report on that, and as the bill moves forward somebody might have to go to testify in committee, but I believe it will probably just pass on through. Either way I will keep an eye on the situation. Does anyone have any questions?

There were no questions for Barry

Mark Rieger joined call at 12:06 MST.

Marilyn: Next on the agenda are the committee reports. We'll start with the Edit Committee

COMMITTEE REPORTS

Edit Committee – Beth Wright and Mark Painter

Beth: In short, we have gone through all of the 20012 modifiers both CPT and HCPCS and completed our review of those. This document (Modifiers_20_121212_20edited.pdf) reflects where we were as of December, and identifies modifiers that we felt were important HCPCS to reimbursement payment rules. There are a lot in here that are informational as well as a lot that seemed to be completely out of scope. We still have to migrate in the 2013 modifiers. I do not believe there was any for CPT and we will just have to see what needs to be looked at for 2013 HCPCS modifiers and add those in. Now we didn't present this for consensus at this point because everybody has not had enough time to look it over, but we will look to get consensus on it in February.

Barry: While we don't need to call for consensus, we do have it up in front of us right now. Can you walk us through a little bit of what you are going to be looking for consensus on?

Beth: In general I think that the grid itself is fairly self-explanatory, at least with the comments. I am interested in folks providing feedback from the data they have seen as to which modifiers are important. I want to see if perhaps we have missed some major modifier that is important. There is also some in here that we listed as being referred to the Payment Rules Committee. This is where we really need a strong collaborative effort from the two committees which we have. If you look at this document, the majority of modifiers, especially the Medicare ones, are either informational or out of scope. If we felt that a modifier was a payment modifier we made an effort to tag the items in the statute that we feel it would point back to. So if you had a site specific modifier we might have said, “we think these modifiers could be important to editing for frequency, unbundling, and mutually exclusive” just as an example. So I’m not asking for everyone to pick through this with a fine-toothed comb, but if you see something that is jumping out at you that would be very important to us to know that we missed something.

Action Item: Edit Committee asks task force to look over modifiers list before February Meeting

Marilyn: When we say “important” we mean that if the payment modifier can possibly override edits. What else when we say “important” did we look at?

Beth: I think that’s it in a nutshell. Important to us is that it impacts the payment of the claim. So you can see that there are a lot of informational modifiers in here that Medicare might use to support Medicare payment policies, or some program that they have, but it does not impact from a commercial perspective the way we process a claim. Everyone knows the modifiers 25 and 59. Those, to us, are very important modifiers. They are important to the provider and tell us that the provider feels that there is something significant about this work. So from a payment perspective that is what we’re looking for; something that says, “Listen its either going to be something I’m going to use to pay the claim with differently, *or* it can be used to override an edit.” So we could give an example of Modifier 22, the top one on the list, which is a payment modifier. Today, it doesn’t override any edits, but it does trigger how most payers would handle a claim. If the modifier 22 is on there the provider is telling us, “We think there is some complexity and increased level of work to this, over and above the standard reimbursement for this procedure on a regular basis. So we want you to take a look and compensate us.” While we have made consensus that we are not going to discuss the percentages that we would pay these, are there rules around it that the Payment Rules Committee might want to consider?

Marilyn: When we say “definition,” we intended to take those straight from CPT and HCPCS and not come up with our own right?

Beth: Well the CPT ones are much easier to spell out. We did spell those out completely right from the CPT book. When you get down to the HCPC ones, some of them are lengthy so we used the short descriptions. So yes, we did not make any of these up.

Jim: I just wanted to clarify something, when you say “out of scope” you mean out of scope of the task force correct?

Beth: Yes sir. Out of scope meaning we have determined that it is out of scope of the legislation.

Jim: Got it. Thank you.

Beth: So that’s where we stand with the modifier grid. We do not need consensus today, but we certainly need to know if we missed anything because that is going to be the basis for our next layer of work and the work that the Payment Rules Committee is doing.

Lisa: Hello it seems that I was left off that email and I do not have the modifier table. Connor or Marilyn please send it to me.

ACTION ITEM: Connor will send modifier table to Lisa

Marilyn: So are there any more questions for Beth?

Barry: So in layman's terms Beth, these things then are part of what we will begin to use in our analytics engine, once we acquire that, to drive the uniform set forward. Is that correct?

Beth: Yes, and that's a nice lead into the second part of the work we're doing. We have started a process of looking at the specifications, the requirements, and the queries; that kind of information that we believe the DSR committee is looking for as we begin the process of taking one rule from end to end. So now we are starting to pull some of these things together. We had our first level of definitions that we built around the actual edits in the statute, and now we've got this next piece of breaking down the modifiers which are very important to those edits. Then we need to be able to put all of those things together and be able to tell the DSR committee what we want to see happen. So what we started the process of doing is laying out this simple grid for assistant surgeon. We got our definition, we've summarized our decision path on how we are going to decide when an assistant surgeon is eligible for compensation, we noted those modifiers that are important to that definition, and then talked about what kind of information we would see in a query which are: the CPT code, an indicator of either *always*, *never*, or *sometimes*, the source where the information came from, the type of edit, and from and through effective dates. We also talked about how we would want to create a historical trail so that we would know when something changed.

Mark R: Are you thinking that the assistant surgeon rule would be your recommendation for the process the DSR is interested in? It seems close, but probably needs a little more work to get it over the hump.

Beth: We agree. What we need from you is what you think it takes to get over this hump. One part of the process that we haven't begun to tackle is an appeals conversation.

Barry: I want to make sure I know what I am looking at here, I think I do: So this is a starting place for what we've called our *governance*, and a trial-run for developing the governance model? Or is this material that really belongs in the RFP for the analytics?

Beth: It is more that latter piece Barry. This is something that we would want to see in the RFP.

Mark R: Let me suggest something: I think from the DSR perspective it would be going from what we're seeing here in terms of the technical workout around the assistant surgeon rule. Going from that document and, let's say an eventual set of instructions to a technical vendor, going from that to effective 1/1/2015, if you pay a claim in the state of Colorado that involves assistant surgeon rules, this is how you have to do it. How do we go from what we're seeing here in terms of the rule, to complete comfort that the rule becomes effective on 1/1/2015? Whatever you have to fill in between that is the governance piece in our eyes.

Beth: I see this as the "pre-work" and the "post-work." The pre-work is all of this stuff that we are doing, and then coming up with that final assistant surgeon list. Then we are going to produce something for the provider community to display what it is that we have developed. We haven't talked much about this post-work.

Mark R: One of the things the DSR is trying to press on is what are all the supporting documents that need to be available to the decision making process? Part of the DSR's ask is that we have to get a consensus on what is the minimum information that is required for this. Beth is touching on how mature does this work product have to be before it's ready for an implementation decision, and by what method will contention be resolved for that decision.

Beth: Right

Marilyn: Ok. Beth did you have anything else from the Edit Committee?

Beth: I was going to ask Mark Painter if he had anything to add, but I think that is all we had.

Mark P: I have nothing further to report

Marilyn: Ok. Moving on with Lisa from the Payment rule Committee...

Barry: Pardon the interruption, but I wanted to say something before Lisa begins. We are very sad to be losing one of our original task force members, Catherine Hanson from the AMA, who is leaving the AMA as well as her seat with the task force. As a result, Tammy Banks will move into what we call the formal seated position for the AMA. This leaves us needing an alternate so that we always have a member from the AMA aboard our meetings. Lisa Lipinski, who has been working very hard since mid-last year, applied for that position. I wanted to take this opportunity to say that I just received an email saying that Lisa has been formally seated by Director Birch of Health Care Policy and Finance as of this moment, so Lisa can now speak as an officially seated task force member, and vote as required. Lisa, thank you for everything you do and please carry on.

Rules Committee – Lisa Lipinski

Lisa: Wonderful. Thank you. Katherine has decided to go back to California and practice privately as a health care attorney and advocacy consultant. She has brought great leadership and knowledge and I know she will miss working with the task force. So to move forward with the Payment Committee, we had a meeting yesterday. We were working on the payment rules for bilateral and global. We also put together the first draft of a recommendation template for all the rules. This template includes description of the rules, codes subject to the rule, modifiers, and additional information someone would need surrounding that rule. Based on some of the committee discussions, we are going to modify that so we do not have anything to bring to consensus yet. For the bilateral payment rule that we went over, we are revising the introduction that I put together but we are getting pretty close to completion with it. We are aiming to have the template and both of these payment rules finalized and sent out at least five days prior to the face-to-face meeting next month. So that's what I had, does anybody have any questions?

Barry: Lisa, as is the Edit Committee, the work you are doing is right at the core of our task force charter and objectives. When you meet, are you making a point to really have a good cross-section of representation of stakeholders? You do not necessarily have to have all of the stakeholders every time, but certainly a good cross-section is necessary. Is that something which the Committee has been able to accomplish?

Lisa: I believe so. There are insurers on there, physician representation, and we have been reaching out to the Federation which is the specialty societies and medical societies out there to make sure that they have a proper voice at the table as well. With that said, if there is anybody you feel is missing please encourage them to join the committee because the more stakeholder representation we have, the better and stronger these recommendations can be.

Specialty Society – Helen Campbell

Marilyn: Thank you. Since Helen and Tammy are not on the line, we do not really have a specialty society report for this meeting.

Barry: That is unfortunately the case, but I believe that there were some people representing specialty societies on call. If we could have these people come forward with your name and which society you're representing, that would be appreciated and we can make note of it in the minutes.

The following people were present:

- Jenny Jackson, American College of Surgeons
- Pam Kassing, American College of Radiology
- Dayene Hayek, American College of Radiology

Marilyn: Mark Painter it is my understanding that you got some interest from another specialty society that would like to sit in on the calls. Would you like to comment on this?

Mark P: Yes. The Society of Thoracic Surgeons would like to put one of their staff members on as “invited public” so they will be joining us in the near future.

Marilyn: So now we are up to the Data Sustaining Repository Committee with Mark Rieger and Val Clark.

DSR Committee – Mark Rieger and Val Clark

Mark R: Thank you. We have not met as a committee since our last recommendation, and I think our update is essentially to encourage participation in the discussion that will take place later today regarding the governance method.

Marilyn: Ok, and did you come up with a set day of the month for your meetings moving forward?

Mark R: We are still working on coming up with the best meeting time for everybody.

Barry: I do want to encourage you to expedite that. This committee will be carrying a heavier load moving forward and it is important that we come together on this. At this point I am going to recommend that we move on to that DSR discussion, and I will defer my two committees to the end of the discussion today. I think this is the meatiest part of the discussion today, and I just have a couple small things to report.

DSR request to the full task force- Mark Rieger

Mark: I think our hope today was to reach a general consensus as to what rule we wanted to use as the test case for the final decision making process, so it sounds like assistant surgeon is being prepped for that, but we can consider other rules as well. If there’s time to work on what content about that rule needs to be available for the final decision making process I think that we would be in a good position for next meeting.

Jenny: Hi this is Jenny from the American College of Surgeons, and we have a concern regarding the placement of the *sometimes* category. Our assistant surgeon is broken up into three categories: *almost always*, *almost never*, *some of the time*. So really it would just be one category of codes, the *almost always* that would never be denied, where the other two categories would always be denied and require additional documentation. Well the majority of the documents fall into the *some of the time* category, so the majority of the codes would be denied and require additional documentation. We do see that potentially being an issue for the surgeons we represent, and saying that this is based on physicians as assistants document.

Barry: Mark, I recall at a meeting that we went through about 5,000 codes and found that only 375 would fall into this category. You were the one that did the research on that, am I remembering that correctly?

Beth: I think Mark may have left, but you are right Barry the data was very low. Jenny, I am not sure if you saw the whole process, but we wouldn’t automatically deny the *sometimes*, if ACS recommends a *sometimes* or *silent* we then default to the CMS list. We are only defaulting to a *never* if both parties have a *sometimes* value. So to Barry’s point, there is a very small collection of codes that fall into that category.

Barry: Right, it was my recollection that less than 5% fell into this category. It sounds as if you were under a different impression, and maybe you didn't consider the CMS views, but that's a fairly significant issue for us because we need to have a uniform set of codes. The *sometimes* is problematic but it would be much more so if it were half of these codes were in this category. Where is your data coming from?

Jenny: Well I am just looking at our document, and the majority of the codes in the physicians as assistants at surgery report are in the sometimes category. Now I haven't compared it to CMS categories, but I know that a lot of their designations match many of our designations.

Beth: Yea. So we will take your recommendations on the always and never, and we are not going to go past that. We would prefer to have an ACS recommendation on all of them, and I'm sure this is not the first time you've heard this, but we would certainly love to see a more frequent update to the documentation. Then the sometimes category from our perspective we are looking to reduce administrative expense and so the consideration we gave to having to require a record review was one we took in consideration, we were trying to cut that out. So we want to be able to have a list that providers know up-front it's either always or never. So in the end our publication will have a list of either always or never, and that decision tree that I laid out for you is how we get to that final list.

Jenny: We would definitely be interested in looking at a final draft/list of where things fall. I know we have some stuff that is classified as *almost never* which doesn't mean that it would *never* occur but it would be rare.

Beth: Right. And providers always have the right to appeal, and that is something that we are laying out in our documentation. We understand that there will be situations that will warrant a review and extreme cases would warrant an overturn.

Barry: Jenny, I think that you will find that the second bullet under number three covers a lot of this, and greatly reduces the number of contentious codes. I invite you to read this section and I think that you will feel more comfortable with the approach we are taking. I would also like to say that we are thrilled to have someone from ACS begin to directly engage with us, and your opinions are welcomed at any time during these discussions. We value your input and want you to fully engage in the conversation all the way through.

Jenny: Ok. I was also just going to say that we do try to update the report as often as possible. As you can imagine, we have several different societies trying to update so it doesn't always occur as timely as we would like. However, we are updating it this year and it should be coming out soon.

Beth: Oh yes, we can definitely understand and respect that. I would also like to add that we value the ACS opinion and would love for it to be a primary choice for our list. Much of CMS's list is driven by volume data where we feel that you are really getting at the clinical which is much more important. However, we recognize that because you don't produce a list every year we needed an alternate source to help supplement those off years and *sometimes* category.

Jenny: Thank you

Marilyn: Lisa, I will get Jenny's email from you so we can include her on the distribution lists.

Lisa: Ok sounds good. I do just have a question to make sure I am understanding things correctly. So if we put this in development can we go back and change things later?

Barry: Absolutely. All of our rules are for the development of the analytics, and to give us the capability to make informed decisions as to whether or not we have what we want here. So first we need a development vehicle, and then we really have to assess these things for their impact. So yes, the answer is that they are changeable by consensus.

Marilyn: So getting back to this document, I am not sure if this is what Mark R and the DSR was looking for, or what we would need to add to it. Number four is to query the data sustaining repository and evaluate results for consistency with the proposed rule. This is what Beth was talking about earlier with what the edit committee was doing in trying to identify what we would be querying for; that's the information that we would use then to evaluate our working rule. Then we look at it and see if it is consistent with what we were expecting. If not, we then try to identify why. Then we document the findings for the public, and present the rule with our finding to the task force for consensus vote. Then we get to the publication process. There is a formal process through this state, similar to what the federal register does in terms of publishing the proposed rule, allowing 60 day comment period. I don't know if we want a public hearing or not, but we would have to identify any existing communication mechanisms such as through the AMA, payers, or vendors. So I was wondering if this is at least a start to what Mark Rieger was looking for.

Mark R: Again, the goal of the DSR right now is to treat assistant surgeon as if we were going to put it into production as soon as practical. I don't see any technical, political, or any other barrier to actually putting it into production. It might not have a go-live date, but there's no reason this rule can't be moved to the point of available for production. If it needs to be updated between when it is approved for production, and when it is approved for implementation, we can do that. I think that helps to capture this discussion around the edges. The DSR wants to see the task force take one rule and move it into production. I would encourage the group to think of production as *now* and say is there any reason we can't put assistant surgeon in production 5/1/2013?

Barry: We have to be careful here on our terms with production vs. implementation. The statute does not allow us to put the rules into effect any sooner than when we put them all into effect. Now, can we test them? Can we test them publically? That is a different question and we can talk about that, but let's be careful about the terms we use here with production vs. implementation.

Mark: Ok, then maybe today we create a lexicon that satisfies our goal. Remember the goal here is to take one rule and get it all the way through, end to end.

Barry: Yes.

Mark: I would say that the date 1/1/2015 is so far away that in order to have a sense of urgency that we need to have to be able to get comfortable with what the governance process is. In other words we need a deadline.

Barry: I certainly think that we as a task force can add a consensus based deadline for evaluation of a rule, and acceptance of that rule into the common set. Initially here we are going to go "onesie-twosie" with the things. Then later on we will do it volumetrically as we have the full data analytics engine available. So in terms of public response, including response time and appeal period, that's something I think we want to have in discussion in part of this governance. I agree we do need to have the ability to say, "Ok, we think that rule stays let's move on to another one." We can't have 100,000 rules in flux a month before we are supposed to go to implementation, but I would call that the public review period for this particular rule. We are going to test our governance process with this rule and what we come out with is a finished product. Now, this is just one of many, but it will be the first finished product.

Marilyn: To take it to the final conclusion are we going to ask the payers/vendors on the task force to test it?

Beth: From a timing perspective it seems that we are taking months and months off our timeline to get things done. A public review period is probably a 3 month cycle at least, probably more like 4 months. Then what you are saying Marilyn would add even more time so it has me a little concerned.

Mark R: From my standpoint, the conversation that is evolving here is exactly the type of conversation that we need to have. Beth raises some very practical questions. To my knowledge there is not very much detail from our charter/legislation around exactly how to construct this process, so that is up to this group to decide. For instance, I don't think there is anything that obligates us to a testing period, we just think it would be a good idea. So this is exactly the purpose of our ask, to work through all these little details and create the process that can now be extended through the entire rules set.

Barry: I would like to get Doug's comment here.

Doug: I think that I had more of a basic view of the step that we're presently taking. In order to create a repository where these edits could be displayed so that the public could look at these, we need a step called user requirements where we know that a file of edits (like assistant surgeon) is going to take a certain amount of room, certain amount of lines, etc. A specification needs to be developed so that it is stipulated in the RFP that the system needs to do the following things. By taking a rule and starting through that process, we can start to answer some of these things involving fairly basic design requirements. By looking at a rule all the way from the front to the back we would get a sense of the scope of work for the first release that we would need to specify within the RFP so that a vendor would actually be able to actually design, build, and deliver. I think all of the edits and review issues that were just mentioned about content *are* part of the content and may or may not be supported in the first release of the repository. Clearly we will need to be able to post changes, but that can be simple or elegant. Those are some of the things that will make a big difference in total cost, and we need to get down to the specifications of what we are saying we want in order to get a vendor, or anybody else to help us to provide that.

Marilyn: I think that this document was coming from a different point of view. It wasn't coming from the point of view of the RFP and what the DSR would do. It was coming from the point of view of the process that we followed.

Doug: Well I think that both of those are relevant. I have talked about the anatomy, or the names of the parts, (data file web server etc.) and the physiology, which refers to how these things interact. A design for this data sustaining repository needs to describe both of these things in order to be real, so I was looking at it, to some extent, from what are the parts that we need in addition to the functions.

Barry: Thanks Doug. I agree with both perspectives here.

Doug: I am describing it from the sense of the data sustaining repository overall. We have both of those functions, and the work that Mark described in the list of requirements is a huge step in obtaining a draft idea as to how assistant surgeon should work.

Barry: I do understand what you are talking about. In fact, I have been, and remain concerned that the RFP is weak in some of the stipulation which I am just not knowledgeable enough in this work to put in there myself. It is part of what I continue to solicit to the task force members to make the RFP a real thing. So if we could come back to this principle of governance, we are tasked with creating a set of edits that must be credible. In order for them to be credible there has to be an acceptance of how we got to where we got and it's fairly mechanized. The robust conversation that we are hoping to have in February is going to be about the governance and not just about it but actually conducting it. We have gotten into that conversation this afternoon, and, to Beth's point, I think that part of what we really do have to think through here is how this all plays on a timeline and what the practicality of that is. To Mark Rieger's original point, that when we are done with assistant surgery, why wouldn't it be a finished product, I agree with that. We can't implement it but we need to make it available for critique. When we talk about production vs. implementation, I think it can be a production item before it is implemented. To me,

production means it's finished and ready for prime time. Putting it out in the showroom and requiring that it be used is different than whether it is finished or not.

Beth: I agree with that. It's nice to have the guidelines, policies, and decision tree for example that we laid out for this particular edit, but in the end we are going to have to produce an actual list. So in the end, after we go through our two sometimes, we made a decision that we will be a never. Say we produce the actual list and do the analysis side of it and find that we do not agree with this list, at what point then would you want to put it out for public consumption? To me, until we have actually approved the list it is not ready for public consumption.

Barry: When you say "actual list" do you mean the whole list?

Beth: Yes, because I really do think that providers want to see that whole detail.

Barry: In terms of the public for this preliminary vetting, as far as I'm concerned, this refers to the cross-section of stakeholders at our table. When we go out to the *greater public*, maybe that should be the full set. Perhaps we develop some individuals here so that we can vet our process. What I am really concerned with right now is vetting our process; can we do this? As of right now I see no evidence that this can be done. To me, the evidence will be that we've done one, and actually agree and accept what we've come up with. What we call the "public" in that part of the process is maybe a difference between where Beth, Mark, and me might be, is that possible?

Marilyn: When we drafted this document we were trying to leave it in a format that could be used by the entity that runs the data sustaining repository in the future. When I got down to the consideration for a public comment period I was referring to the public in general as the task force has been part of the process all along.

Barry: Ok Marilyn thanks for that clarification, and that is what we're after here. The process going forward shouldn't be a different process than what we do initially other than perhaps the broader publication review period. The rest of this pertains to what we're doing, and I think the reason that we had this document in front of us today is to prepare us for what will be a central theme at our February meeting which is to develop a rule. We wanted everybody to come to that meeting with an understanding of this and allow an opportunity for everyone to pull whatever background information necessary to come to this meeting in an informed way. Do you agree with this Marilyn?

Marilyn: Yes

Barry: Mark Rieger and Mark Painter do you agree that this is what we set out to do here in the DSR Committee?

Mark P: I do. We wanted to at least run this through to a certain degree to figure out what governance hurdles we had and what decisions we could make along the way.

Barry: Ok that's what I thought too, and, as is often the case when you first see a document, it can be viewed in many contexts. So backing up a little bit here, Beth I need you to come in February prepared to help us develop the rule around assistant surgeon, do you have enough information from this outline to know what you're going to be asked to do?

Beth: I guess I do not exactly have the full picture on what we're going to come up with. As Marilyn has documented, we made the decision about how to create the list for assistant surgeon, which is going to be relatively easy compared to some of the other things we will be challenged with. That said, I think I am ready.

Marilyn: I think if everybody could look at it with their point of view and come prepared with the additions that are required to make this a complete document, such as Doug's comments around the anatomy of this. So what's

missing? Mark Rieger talked about the minimum set of information that is necessary before implementation. Then we also need to consider the decision making information as well as the decision making process moving forward.

Beth: Just to clarify Marilyn, this is all pre-implementation correct?

Barry: Yes

Beth: So we're not touching the post-implementation part?

Barry: Correct

Marilyn: What about the appeals process?

Beth: Well, I think you have an appeals process in here if we are going to allow for comment from the public, then reconsideration, to me that is sort of like an appeal.

Barry: It is an embedded appeals process.

Beth: Pre our final implementation dates.

Barry: Correct

Beth: Then we have to lay out what we want to see after implementation, but do we all need to have a post-implementation plan in our heads before next month?

Barry: No

Marilyn: But I think the thought was that the post shouldn't deviate that much from our initial process.

Lisa: I have a question. As we move forward with trying to decide on a rule to use for the development of the DSR, the Rules Committee has not looked at the assistant surgeon rule yet, and I need to know what work our committee has to do with this.

Marilyn: If I remember the timing correctly, I think the assistant surgery rule was one that had a consensus vote prior to the Rules Committee being set up. I think it would be helpful if the Rules Committee would take a look at the rule, and if you're not comfortable with it we would need the rationale why.

Lisa: Ok. Also, I know that the Rules Committee has done a lot of work on the bilateral, would that be another one we can bring forward? Would we follow the same format that we are looking at now with the assistant surgeon?

Marilyn: Yes.

Lisa: Ok thank you.

Barry: Something that would be helpful to me is, if you could put down your thoughts on the highlights from this document on what vendors have to contend with. I want to compare that with what is in the RFP currently, and I will send that once we get off the phone.

Marilyn: Tom Darr, are you still on the phone?

Tom: Yes

Marilyn: Ok, well I noticed that you have been quiet today. Do you have any suggestions or comments on how to improve this document process?

Tom: Well, nothing that is significantly different from what everyone else has said.

Marilyn: Ok. I think this should be able get everyone prepared to have a final template we can use for rule development. Is that all for right now Barry?

Barry: I think so, unless there is other folk that want to weigh in on something. Seeing none, Marilyn, you and I will try to break this thing out a little bit more and make it more of a template to do what we are going to do in February.

Marilyn: Ok. So that brings us to you Barry with the Project Management Committee.

Project Management – Barry Keene

Barry: As I mentioned earlier we do have a new staff person, Connor Holzkamp. Barb will be facilitating again in February and through the coming year. I am also hoping to have an actual project manager (other than me) if our funding will allow it. Finally, our major and recent objective in the Project Management was our report to the legislature. I will continue to monitor our legislation and make sure to guide it through the state house. As many of you are already aware of, even after it passes the state house it takes time for the Governor's office to sign off on it. That means we won't officially have our additional year until near the end of the legislative session. I will keep you posted on how that goes, but if you would like to track it yourself I believe it is Senate Bill 06_659. As soon as it is re-released with the amendments that we put into it I will get a copy out to everybody. Also, I am pleased to begin to see more of the specialty societies actively coming to the table. We appreciate your participation and we hope that this will be beneficial to all of you who suffer from this claims process. So that's all I have on the project management side of things, are there any questions? Hearing none I will move on to Finance.

Financial – Barry Keene

As you are familiar, we were told by the Health Foundation to resubmit our budget and request for grant after the legislature heard our report. I have seen to it that letters went to the Health Foundation and the Colorado Trust that were oozing with our accomplishments and good work. Now it is my time to go back to the foundations. We will continue to need support from stakeholders at the table, I'm sure of that. While we may get some appropriation from the Department of Health Care Policy and Finance, I do not see that covering all of our expense. I should know more about financing by the February meeting. Speaking of which, I did mention to you all at the last meeting that I was going to request a sponsor for catering for the February meeting. I do not include catering in our budget; it is something that we have done through sponsors. This is something I am able to hold up to donors to ensure them that their money is being well spent. So do I have a candidate out there that can come forward now?

Beth: Have you reached out to Rebecca?

Barry: I haven't yet. I figure that since Rebecca has been so good for so long, I thought I would try to get some other sources. But if you think that it would be a good idea to kick 2013 off with Anthem's support I certainly will.

Beth: Yes, I'm sure she would be fine with that.

Barry: Thank you very much. You are very gracious, and Anthem has been very gracious in sponsoring the catering several times and we appreciate that. So that is all I have for Finance at this point, do I have any questions? Seeing none we will now move on to public comment.

PUBLIC COMMENT

There was no public comment

OTHER BUSINESS/QUICK RECAP

Marilyn: So Barry and I will work on a template to try and get that out to everybody before February right?

Barry: Right. I would like to get that out in the next 7-10 days, and we may want to engage Barb a little bit in that as well.

Marilyn: Ok, and I didn't hear any other action items that came out of today, did you Barry?

Barry: Beth did ask for people to go over the modifier list and be able to come to consensus on that in February. So if there are any comments on that please send them directly to the Edit Committee to Beth Wright and Mark Painter. Also, Connor please add Lisa to your distribution list and send her the modifiers table.

Marilyn: If there is no other items for today then we will adjourn

ADJOURNMENT

The meeting was adjourned at 1:45 PM MST.

**HB10_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT
TASK FORCE**

**Executive Summary of Meeting Minutes
January 23, 2013**

<p>HB10_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT TASK FORCE Meeting Minutes January 23, 2013, noon-2 PM, MST Call-in Number: 1-866-740-1260 Conference ID: ID 8586314</p>			
<p>Attendees:</p> <ul style="list-style-type: none"> • Amy Hodges • Barry Keene, CC • Beth Provost • Beth Wright • Dee Cole • Doug Moeller, MD • James Borgstede, MD • Jill Roberson • Kathy McCreary • Kim Davis • Mark Painter • Mark Rieger • Marilyn Rissmiller, CC • Robin Weston • Tom Darr, MD • Valerie Clark • Lisa Lipinski 	<p>Staff :</p> <ul style="list-style-type: none"> • Connor Holzkamp • Barbara Yondorf <p>Public: Diane Hayak (ACR) Jenny Jackson (ACS) Pam Kassing, (ACR) Beth Kujawski (UPI)</p>	<p>Meeting Objective (s):</p> <p>Key: -TF = Task Force -TFM = Task Force Member -CC = Co-Chair</p> <p>Parking Lot:</p>	

REPORT TO THE LEGISLATURE-BARRY KEENE

Barry reported to the full task force that “our report was well received by the legislature. Senate Bill 659 is operative now to extend our timeline, and we fully expect the bill to pass.” Senator Irene Aguilar, who is a practicing physician and the chair of the Senate Health and Human Services Committee, has written a letter on

our behalf to the foundations encouraging that they would continue to support us. Additionally, she sent a letter to the Secretary of Health and Human Services, which was parallel to the letter that Sue Birch has penned to the Secretary of Health and Human Services, regarding another one of our recommendations.

Edit Committee – Beth Wright and Mark Painter

In short, the Edit Committee has gone through all of the 2012 modifiers, both CPT and HCPCS, and completed its review of those. The document that the committee drafted identifies modifiers that they felt were important. There are a lot of modifiers in the document that are informational, as well as a lot that seemed to be completely out of scope. The committee still has to migrate in the 2013 modifiers. Beth Wright talked about what still has to be added, “I do not believe there was any for CPT and we will just have to see what needs to be looked at for 2013 HCPCS modifiers and add those in.” Beth also asked the members of the task force to look over the modifiers table to see if there is anything they might have missed. The Edit Committee did not present this for consensus at this point, but will look to get consensus on it in February after the task force has had a chance to review the document.

Beth Wright says the Edit Committee “has started a process of looking at the specifications, the requirements, and the queries; that kind of information that [we] believe the DSR committee is looking for as we begin the process of taking one rule from end to end... We got our definition, we’ve summarized our decision path on how we are going to decide when an assistant surgeon is eligible for compensation, we noted those modifiers that are important to that definition, and then talked about what kind of information we would see in a query.” The information that they would want to see in a query include: the CPT code, an indicator of either *always*, *never*, or *sometimes*, the source where the information came from, the type of edit, and from and through effective dates. Beth also talked about how they would “want to create a historical trail so that we would know when something changed.” The Edit Committee believes that the assistant surgeon rule would satisfy what the DSR asked of them, and is interested in what needs to happen to make the rule ready for that process.

Rules Committee – Lisa Lipinski

The Rules Committee is working on the payment rules for bilateral and global. They also put together the first draft of a recommendation template for all the rules. This template includes description of the rules, codes subject to the rule, modifiers, and additional information someone would need surrounding that rule. Based on some of the committee discussions, they are going to modify that template, and do not have anything to bring to consensus yet. The committee is aiming to have the template, and both of these payment rules finalized and sent out at least five days prior to the face-to-face meeting next month.

Specialty Society – Helen Campbell and Tammy Banks

Helen and Tammy were not present to give their report to the task force. However, there were several people on the line representing specialty societies.

The following people were present:

- Jenny Jackson, American College of Surgeons
- Pam Kassing, American College of Radiology
- Dayene Hayek, American College of Radiology

Mark Painter informed the task force that the “Society of Thoracic Surgeons would like to put one of their staff members on as *invited public* so they will be joining us in the near future.”

DSR Committee – Mark Rieger and Val Clark

The DSR Committee is still working to finalize a regular meeting schedule, a process which the Committee recognizes needs to be done soon. The DSR is also working on developing a governance process, and, according to Mark R, “I think our hope today was to reach a general consensus as to what rule we wanted to use as the test case for the final decision making process. It sounds like assistant surgeon is being prepped for that, but we can consider other rules as well.”

During the DSR discussion Jenny Jackson from the American College of Surgeons communicated her concern to the task force regarding the placement of the *sometimes* category, “Our assistant surgeon is broken up into three categories: *almost always*, *almost never*, *some of the time*. So really it would just be one category of codes, the *almost always* that would never be denied, where the other two categories would always be denied and require additional documentation. The majority of the documents fall into the *some of the time* category, so the majority of the codes would be denied and require additional documentation. We do see that potentially being an issue for the surgeons we represent.” Barry responded that, “It was my recollection that less than 5% fell into this [sometimes] category. It sounds as if you were under a different impression, and maybe you didn’t consider the CMS views... I think that you will find that the second bullet under number three covers a lot of this, and greatly reduces the number of contentious codes. I invite you to read this section and I think that you will feel more comfortable with the approach we are taking. I would also like to say that we are thrilled to have someone from ACS begin to directly engage with us, and your opinions are welcomed at any time during these discussions. We value your input and want you to fully engage in the conversation all the way through.” Jenny agreed to look over this information again and recognized that she had not considered the CMS view. Beth added that, “providers always have the right to appeal, and that is something that we are laying out in our documentation. We understand that there will be situations that will warrant a review and extreme cases would warrant an overturn.”

Mark R continued the discussion stating, “The goal of the DSR right now is to treat assistant surgeon as if we were going to put it into production as soon as practical... If it needs to be updated between when it is approved for production, and when it is approved for implementation, we can do that.” The DSR plans to test the governance process with this rule, and “what we come out with is a finished product. Now, this is just one of many, but it will be the first finished product” said Barry.

The task force members had several comments/concerns about this process. Beth and Mark R both aired their concerns about the timeline for this goal. It was determined that a consensus based deadline will be needed for evaluation of a rule and acceptance of that rule into the common set.

Doug had a different perspective, and discussed the *anatomy*, or the names of the parts, (data file web server etc.) and the *physiology*, which refers to how these things interact. According to Doug, “A design for this data sustaining repository needs to describe both of these things in order to be real anatomy, or the names of the parts, (data file web server etc.) and the physiology, which refers to how these things interact. A design for this data sustaining repository needs to describe both of these things in order to be real.”

At the end of the discussion, Marilyn encouraged its members to, “Look over **the document** from their point of view and come prepared with the additions that are required to make this a complete document, such as Doug’s comments around the anatomy of this.” The task force will look to develop this during the February meeting where they will be creating the rule around assistant surgeon. The Rules Committee was asked to look at the assistant surgeon rule before the February meeting and provide their rationale if they are not comfortable with what the Edit Committee came up with. The Rules Committee also stated their intentions to bring the bilateral rule they have been working on to the task force in February.

Project Management – Barry Keene

The task force welcomes its new staff member, Connor Holzkamp, who is attending his first task force meeting. Barb will be facilitating again in February and through the coming year. Barry is also hoping to have an actual project manager (other than him) if funding will allow it. Finally, Barry stated, “The major and recent objective in the Project Management was our report to the legislature... As many of you are already aware of, even after it passes the Statehouse it takes time for the Governor’s office to sign off on it. That means we won’t officially have our additional year until near the end of the legislative session.” Barry will continue to monitor the progress of Senate Bill 06_659 as it makes its way through the Statehouse.

Financial – Barry Keene

Barry explained how “we were told by the Health Foundation to resubmit our budget and request for grant after the legislature heard our report. I have seen to it that letters went to the Health Foundation and the Colorado Trust that were oozing with our accomplishments and good work. Now it is my time to go back to the foundations.” He went on to reiterate the importance of financial support from stakeholders as the appropriations from the foundation will not be enough. Barry concluded his report by asking if there was anyone on call that could provide the catering for the February meeting. The task force will graciously look to Anthem once again to cover this expense.

CPT 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 pending; 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>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 addition work <ul style="list-style-type: none"> – 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>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 	<ul style="list-style-type: none"> • Examples of typical anesthesia services <ul style="list-style-type: none"> – Preoperative and postoperative visits by the anesthesiologist – Intraoperative anesthesia care – Insertion of airways and intravenous lines – Intraoperative interpretation of perioperative laboratory tests • Examples of medically necessary surgical

CPT Modifiers

Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
			<ul style="list-style-type: none"> – Qualifying circumstance codes • Some payers do not accept anesthesia codes; instead require use of codes from Surgery section of CPT codebook • 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 Reporting Anesthesia Services <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 Physician Status Modifier <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 	<p>and medical services provided by 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) • 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 • 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

CPT Modifiers

Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
<p>Modifier 24: Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period</p>	<p>Description: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.</p>	<p>Payment modifier Can override an edit --- 'G' global surgery days</p>	<p>procedural services are coded and reported in addition to the anesthesia procedure code</p> <p>Guideline</p> <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>This modifier is primarily intended got use by the surgeon. Inmost 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

CPT Modifiers

Modifier	Modifier Definition	Edit Committee Comments	Payment rule committee guidelines	Payment rule Committee Comments
				<p>during preoperative or postoperative period with modifier 24, submitted documentation must show that critical care was unrelated to the injury or surgery</p> <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
<p>Modifier 25: Significant Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service</p>	<p>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 other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the</p>	<p>Payment modifier Can override an edit:</p> <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 	<p>Guideline</p> <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 	<p>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.</p> <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,

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	<p>relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or 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. 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 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 – E/M service can occur at same visit when a surgical procedure is performed – Not restricted to a particular level of E/M service Supportive Phrasing for Modifier 25 • “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 	<p>separately identifiable E/M service on the same day as a minor surgical procedure</p> <ul style="list-style-type: none"> • Documentation on patient’s medical record <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

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			<p>procedure performed</p> <ul style="list-style-type: none"> 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 problem-oriented E/M service Many carriers pay for only the preventive service when two E/M services (well and problematic) are billed during the same patient encounter 	<p>the same date</p>
<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 <ul style="list-style-type: none"> 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 	<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

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			hospital patients • Medicare carriers can pay the technical component of pathology services when: – An independent laboratory provides services to an inpatient or outpatient of a covered hospital – The laboratory provided the technical component of 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	Informational – Not a payment modifier Doesn't override edit	Guideline Local anesthesia not included: is already in the surgical package	– Does not recognize modifier 47 – Does not cover anesthesia services provided by the

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	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.	Not really used by payers – Most don't allow anesthesia by surgeons	<ul style="list-style-type: none"> • Modifier not for use if surgeon monitors general anesthesia provided by: intern, resident, certified RN anesthetist, anesthesiologist 	surgeon or physician separately
Modifier 50: Bilateral Procedure	Description: Unless otherwise 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.	Payment modifier Critical to editing – N- Bilateral procedures Refer to payment rules committee for rules about how to bill.	Guideline 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. 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. 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. Copyright 2007, American Medical Association 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:	The bilateral modifier is used to indicated 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. 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

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			<p>☐ specifically state the procedure/service may be performed either unilaterally or bilaterally (eg, 58900, Biopsy of ovary(s)); or</p> <p>☐ specify the procedure is "bilateral" (eg, 78458, Vein thrombosis images, bilateral); or,</p> <p>☐ reflect multiple anatomy (eg, 73520, X-ray exam of hips).</p> <p>It is not appropriate to append modifier 50 to the radiology procedure (70000 series) codes, as there are other modifiers to designate separately identifiable procedures (eg, modifier 59). The use of specific modifiers is carrier dependent.</p>	<p>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>
<p>Modifier 51: Multiple Procedures</p>	<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). 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 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 	<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</p>

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			<p>procedures performed at the same session by the same provider. 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>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 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.</p>
<p>Modifier 52: Reduced Services</p>	<p>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</p>	<p>Payment modifier Doesn't override edits Most apply a percentage without review (P)</p>	<p>Guideline</p> <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 	<p>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).</p> <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

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	a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).			
Modifier 53: Discontinued Procedure	<p>Description: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. 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</p>	Payment modifier Doesn't override edits Most apply a percentage without review (P)	<p>Guideline</p> <ul style="list-style-type: none"> • Used to report circumstances when patients experience unexpected responses that cause procedure termination • Not used for reporting ASC facility services <ul style="list-style-type: none"> – See modifiers 73 and 74 for ASC facility reporting 	<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 before anesthesia induction and/or surgical preparation in the operating suite – For outpatient hospital or ASC reporting • Use modifier 73 or 74 for partially reduced or canceled procedure/service <ul style="list-style-type: none"> – For use with E/M service CPT codes – For conversion of laparoscopic or endoscopic procedure to open or when a procedure becomes more extensive

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	<p>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>			
<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 to the usual procedure number.</p>	<p>Payment modifier It is important in editing – important to recognize the components of the surgical package Most apply a percentage without review (G) - Global</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 	<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>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 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 55: Postoperative Management Only	<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>Payment modifier It is important in editing – important to recognize the components of the surgical package Most apply a percentage without review (G) - Global</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 	<p>package.</p> <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 postsurgical 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</p>

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				<p>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. 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</p>	<p>Payment modifier It is important in editing – important to recognize the components of the surgical package Most apply a percentage without review (G) - Global</p>	<p>Guideline • CPT surgery guidelines: surgical procedures include the operation and the following: – Local infiltration; metacarpal, metatarsal, or digital block; topical anesthesia – One related E/M encounter</p>	<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</p>

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	<p>identified by adding modifier 56 to the usual procedure number.</p>		<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 <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 • Guidelines state that subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure (including history and physical) is included in the surgical package 	<p>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> <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,</p>

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				<p>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 package.</p>
<p>Modifier 57: Decision for Surgery</p>	<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>Payment modifier Overrides an edit (G) – Global surgery</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>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

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<p>Modifier 58: Staged or Related Procedure or Service by the Same Physician During the Postoperative Period</p>	<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), see modifier 78.</p>	<p>Payment modifier Overrides an edit (G) – Global surgery</p>	<p>Guideline</p> <ul style="list-style-type: none"> • Revised in 2008 – 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 – 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: <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 	<p>visit is to decide about major surgery</p> <ul style="list-style-type: none"> • Separate documentation not required with claim submission <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> <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 <ul style="list-style-type: none"> – 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</p>

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				<p>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
<p>Modifier 59: Distinct Procedural Service</p>	<p>Description: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive</p>	<p>Payment modifier Overrides edits (A) Unbundle (B) Mutually exclusive (F) Frequency</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 <ul style="list-style-type: none"> – Should be used only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances • 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 	<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 anatomical sites, or at different sessions (on the same day) – 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

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	<p>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>not be reported in addition to the code for the total procedure or service of which it is considered an integral component</p> <ul style="list-style-type: none"> • Examples of CPT codes with “separate procedure” in the code description • 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) 	<ul style="list-style-type: none"> – “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 are used <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

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				<ul style="list-style-type: none"> – 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 the service performed was a separately identifiable diagnostic service • 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,</p>	<p>Payment modifier Doesn't override edits Most apply percentage without review</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</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</p>

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	<p>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 may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.</p>	<p>Tied to (K) Co-Surgeons</p>	<p>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 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>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 <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

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				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 • Neither co-surgery nor multiple surgery rules apply even if the procedure(s) are performed through the same incision • If one performs multiple procedures • Multiple procedure rules apply to that surgeon's services
Modifier 63: Procedure Performed on Infants Less Than 4 kg	<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 patients. This circumstance may be reported by adding modifier 63 to the procedure number. 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,</p>	Informational modifier Could lead to higher percentage reimbursement – need to verify who does this	<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 – 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 	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 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.

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	<p>Pathology/Laboratory, or Medicine sections.</p>		<p>balloon dilation</p> <ul style="list-style-type: none"> • Not for use with procedures for the correction of congenital abnormalities • Not for use with procedures that include pediatric status in descriptors 	
<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>Payment or Informational? Doesn't override edit Some review them and some let them go- Some are reviewed need to verify</p> <p>Tied to (L) Team Surgery</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 (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>	<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 • 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

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				<ul style="list-style-type: none"> – 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 – 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>Payment modifier Overrides edits (F) Frequency (G) – Global surgery?</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 – Procedure performed in an operating room or place equipped specifically for procedures – Medical necessity evident – Identical services performed • Examples – Follow-up X rays – Repeated electrocardiograms – Repeated coronary angiogram or coronary artery bypass
<p>Modifier 77: Repeat Procedure by Another Physician or Other Qualified Health Care Professional</p>	<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</p>	<p>Payment modifier Overrides edits (F) Frequency</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 – Medical necessity of repeated procedure must be evident • Modifier 77 used – When another physician repeats a procedure or service on the same day – For multiple diagnostic tests performed on the same day

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	should not be appended to an E/M service.			
<p>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>	<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>Payment modifier Override edits (F) Frequency (G) Global surgery</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 related to the initial procedure was performed during the postoperative period of the initial procedure • 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

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				<p>intraoperative service of the code that describes the treatment of the complication(s)</p> <ul style="list-style-type: none"> • 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 complication of original surgery <ul style="list-style-type: none"> – Complication rules apply – Bilateral surgery rules do not apply
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	Payment modifier Override edits (F) Frequency (G) Global surgery?	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 	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.

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	modifier 79. (For repeat procedures on the same day, see modifier 76.)		procedure code	<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	<p>Description: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).</p>	<p>Payment modifier Tied to (J) Assistant surgery (F) Frequency – when primary and assistant bill on same claim</p>	<p>Guideline</p> <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 national Medicare claims data indicate a procedure has used assistants in at least 5% of cases based on a national average percentage • Full payment for assistant surgeon's services may be made for some procedures if documentation is provided establishing medical necessity

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				<ul style="list-style-type: none"> • 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, PA, NP, or CNS) • Claims from an assistant-at-surgery <ul style="list-style-type: none"> – 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

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				<ul style="list-style-type: none"> – 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.	Payment modifier Tied to (J) Assistant surgery (F) Frequency – when primary and assistant bill on same claim	Guideline <ul style="list-style-type: none"> • Assistant surgeon services required for a relatively short time <ul style="list-style-type: none"> – Second surgeon provides minimal assistance – Second surgeon reports the surgical procedure code with modifier 81 	<ul style="list-style-type: none"> • Rarely recognizes modifier 81 • For modifier 81 with procedure code with a maximum allowable payment <ul style="list-style-type: none"> – 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 <ul style="list-style-type: none"> – 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).	Payment modifier Tied to (J) Assistant surgery (F) Frequency – when primary and assistant bill on same claim	Guideline <ul style="list-style-type: none"> • Assistant surgeon is usually a qualified resident surgeon • Another surgeon may assist in surgery when qualified resident surgeon not available <ul style="list-style-type: none"> – Nonresident assistant surgeon services reported with modifier 82 appended to procedure code 	<ul style="list-style-type: none"> • Payment not made for assistants-at-surgery services in teaching hospital with training program related to the required specialty and qualified resident available <ul style="list-style-type: none"> – Unless exceptional medical circumstances exist • If the procedure is deemed ineligible <ul style="list-style-type: none"> – Cost cannot be passed on to the patient <p>Exceptional Medical Circumstances</p> <ul style="list-style-type: none"> • Payment is made for the services of assistants-at-surgery in teaching hospitals in the following circumstances: <ul style="list-style-type: none"> – 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

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				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.	Informational? verify	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. 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	Payment Overrides edits (F) Frequency (A) Unbundle (Lab rebundling)	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 • Modifier 59: – 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	• 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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	<p>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 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 modifier.</p>	<p>Informational (P)</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>
<p>Modifier 99: Multiple Modifiers</p>	<p>Description: Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such</p>	<p>Informational Some pend these for review-due to system limitations</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 	<ul style="list-style-type: none"> • Modifier 99 informational only for CMS and alerts carrier that additional modifiers are to follow

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	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.		– Other applicable modifiers may be listed as part of the description of the service	

Attachment B-2

HCPCS Modifiers

Modifier - Modifier Definition	Edit Committee Comments
Modifier AA : ANESTH SVC PERFORMED PERSONAL	Anesthesia modifier – group with all anesthesia
Modifier AD : REIMB ANESTH > 4 PROC	Anesthesia modifier – group with all anesthesia
Modifier AE : Registered dietician	Out of scope – not dealing with provider type edits
Modifier AF : Specialty physician	Out of scope – not dealing with provider type edits
Modifier AG : Primary physician	Out of scope – not dealing with provider type edits
Modifier AH : Clinical Psychologist	Out of scope – not dealing with provider type edits
Modifier AI : Principle physician of record	Informational
Modifier AJ : Clinical Social Worker	Out of scope – not dealing with provider type edits
Modifier AK : Non participating physician	Out of scope – not dealing with provider type edits
Modifier AM : PHYS TEAM MEMBER SVC	Informational
Modifier AP : REFRACT STATE NOT DETERMINED	Informational
Modifier AQ : By phys in unlisted HPSA	Informational
Modifier AR : Physician serv scarce area	Informational
Modifier AS: PA, NP, asst at surgery	Payment modifier Tied to (J) Assistant surgery (F) Frequency – when primary and assistant bill on same claim
Modifier AT : Acute Treatment	Informational
Modifier AU : FURN W/ UROL, OSTOMY, TRACH SU	Informational
Modifier AV : FURN W/ PROSTH OR ORTHOTIC	Informational
Modifier AW : FURN W/ SURG DRESSING	Informational
Modifier AX : FURN W/ DIALYSIS SVC	Informational
Modifier AY : Item not for treatment of ESRD	Informational
Modifier AZ : Dental shortage area EHR pymt	Informational
Modifier A1 : DRESSING FOR ONE WOUND	Informational
Modifier A2 : DRESSING FOR TWO WOUNDS	Informational
Modifier A3 : DRESSING FOR THREE WOUNDS	Informational
Modifier A4 : DRESSING FOR FOUR WOUNDS	Informational
Modifier A5 : DRESSING FOR FIVE WOUNDS	Informational
Modifier A6 : DRESSING FOR SIX WOUNDS	Informational
Modifier A7 : DRESSING FOR SEVEN WOUNDS	Informational
Modifier A8 : DRESSING FOR EIGHT WOUNDS	Informational
Modifier A9 : DRESSING FOR 9 OR MORE WOUNDS	Informational
Modifier BA : FURN W/ PEN SVCS	Informational
Modifier BL : Special acquisition of blood	Informational

Attachment B-2

HCPCS Modifiers

Modifier - Modifier Definition	Edit Committee Comments
Modifier BO : ORAL FORMULA	Out of scope – derives benefit or fee schedule payment
Modifier BP : Purchase Option Beneficiary De	Informational
Modifier BR : Purchase Option Ben to Rent	Informational
Modifier BU : Purchase Option Did Not Respon	Informational
Modifier CA : PROC PAYABLE INPATIENT	Out of scope – fee schedule payment related to ASCs potentially
Modifier CB : ESRD BENE PART A SNF-SEP PAY	Informational
Modifier CC : Procedure Code Change	Informational
Modifier CD : AMCC test for ESRD or MCP MD	Informational
Modifier CE : Med neces AMCC tst sep reimb	Informational
Modifier CF : AMCC tst not composite rate	Informational
Modifier CG : Policy criteria applied	Informational
Modifier CR : Catastrophe/Disaster Related	Informational
Modifier CS : Related to 2010 gulf oil spill	Informational
Modifier DA : Oral assess other than dentist	Out of scope – not dealing with provider type edits
Modifier EJ : SUBS CLAIMS/SOD HYALURONATE	Informational
Modifier EM : ER Supply, Alpha-EPO Inj only	Informational
Modifier EP : PART OF EPSDT PROGRAM	Informational
Modifier ET : EMERGENCY SERVICES	Informational
Modifier EY : NO PRACTITIONER ORDER FOR SVC	Rocky – requiring that all claim lines on claim have EY –otherwise require claim split- Medicare only - should be denied WLP – will be using in future Can't create an edit to support Out of scope – benefit related and administrative related
Modifier E1 : Upper Left, Eyelid	Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier E2 : Lower Left, Eyelid	Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier E3 : Upper Right, Eyelid	Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier E4 : Lower Right, Eyelid	Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive

Attachment B-2

HCPCS Modifiers

Modifier - Modifier Definition	Edit Committee Comments
Modifier FA : Left Hand, Thumb	Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier FB : Item provided without cost	Out of scope – fee schedule related
Modifier FC : Part Credit, Replaced Device	Out of scope – fee schedule related
Modifier FP : Service part of Fam Plng Prog	Out of scope – benefit related
Modifier F1 : Left Hand, Second Digit	Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier F2 : Left Hand, Third Digit	Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier F3 : Left Hand, Fourth Digit	Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier F4 : Left Hand, Fifth Digit	Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier F5 : Right Hand, Thumb	Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier F6 : Right Hand, Second Digit	Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier F7 : Right Hand, Third Digit	Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier F8 : Right Hand, Fourth Digit	Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier F9 : Right Hand, Fifth Digit	Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier GA : Waiver of Liabil Stmt on File	Out of scope – benefit related & provider contractual
Modifier GB : NOT COV BY GLOBAL PMT DEMO	Informational
Modifier GC : Svc Perf by Resident under Phy	Informational - potentially contractual – don't pay for residents
Modifier GD : Unit of Service > MUE Value	Payment modifier Rocky – use to over MUE

Attachment B-2

HCPCS Modifiers

Modifier - Modifier Definition	Edit Committee Comments
	WLP – don't use? Humana – doesn't use (F) Frequency
Modifier GE : Svc Perf by Resident w/o Phys	Informational - potentially contractual – don't pay for residents
Modifier GF : NON-PHYS SERV C A HOSP	Out of scope – not dealing with provider type edits
Modifier GG : Screening mammo on same day	Informational – CMS only
Modifier GH : DX MAMMO/SCREEN MAMMO SAME DAY	Informational – CMS only
Modifier GJ : OPT OUT PRACT EMERG SVC	Informational - CMS only
Modifier GK : Actual Item/Service Ordered	Out of scope – benefit related & provider contractual
Modifier GL : Upgraded Item, No Charge	Informational – CMS only
Modifier GM : MULT PATIENTS, ONE AMB TRIP	Informational
Modifier GN : SVC BY SPEECH/LANG PATH	Out of scope – benefit related
Modifier GO : SVC BY OCC THERAPIST	Out of scope – benefit related
Modifier GP : SVC BY PHYSICAL THERAPIST	Out of scope – benefit related
Modifier GQ : VIA TELECOM SYSTEM	Informational
Modifier GR : Svc by resident(per VA policy)	Informational
Modifier GS : DOSAGE REDUCED DUE TO HCT/HGB	Informational
Modifier GT : VIA INTERACT AUDIO/VIDEO SYST	Out of scope – fee schedule related for Medicaid
Modifier GU : Waiver of liability, routine	Informational
Modifier GV : PHYS NOT PAID BY HOSPICE PROV	Informational
Modifier GW : SVC NOT RELATE TO HOSP PT COND	Informational
Modifier GX : Notice of liability, voluntary	Informational
Modifier GY : Statutorily Excluded	Informational – CMS only
Modifier GZ : NOT REASONABLE OR NECESSARY	Out of scope – benefit related & provider contractual
Modifier G1 : Most Recent URR Read < 60	Informational – CMS only
Modifier G2 : Most Recent URR Read 60-64.9	Informational – CMS only
Modifier G3 : Most Recent URR Read 65-69.9	Informational – CMS only
Modifier G4 : Most Recent URR Read 70-74.9	Informational – CMS only
Modifier G5 : Most Recent URR Read =>75	Informational – CMS only

Attachment B-2

HCPCS Modifiers

Modifier - Modifier Definition	Edit Committee Comments
Modifier G6 : PT W/ LESS THAN 6 DIALYSIS/MO	Informational – CMS only
Modifier G7 : PREG DUE TO RAPE, INCEST, PHYS	Out of scope - benefit related
Modifier G8 : Anesth - Invasive Surg Proc	Informational
Modifier G9 : Anesth - Cardio-Pulmonary Cond	Informational
Modifier HA : CHILD/ADOLESCENT PROGRAM	Out of scope – benefit related
Modifier HB : ADULT PROGRAM, NON GERIATRIC	Out of scope – benefit related
Modifier HC : ADULT PROGRAM, GERIATRIC	Out of scope – benefit related
Modifier HD : PREGNANT/PARENTING WOMENS PRO	Out of scope – benefit related
Modifier HE : MENTAL HEALTH PROGRAM	Out of scope – benefit related
Modifier HF : SUBSTANCE ABUSE PROGRAM	Out of scope – benefit related
Modifier HG : OPIOID ADDICT TX PROGRAM	Out of scope – benefit related
Modifier HH : INTEGRATE MH/SUBS ABUSE PR	Out of scope – benefit related
Modifier HI : INT MH/DEVELOP DISABIL PROG	Out of scope – benefit related
Modifier HJ : EMPLOYEE ASSISTANCE PROG	Out of scope – benefit related
Modifier HK : SPECIAL MH PROG HIGH-RISK POP	Out of scope – benefit related
Modifier HM : Less than bachelor degree	Out of scope – benefit related
Modifier HN : BACHELORS DEGREE LEVEL	Out of scope – benefit related
Modifier HO : MASTERS DEGREE LEVEL	Out of scope – benefit related
Modifier HP : DOCTORAL LEVEL	Out of scope – benefit related
Modifier HQ : GROUP SETTING	Out of scope – benefit related
Modifier HR : FAMILY/COUPLE WITH CLIENT PRES	Out of scope – benefit related
Modifier HT : MULTI-DISCIPLINARY TEAM	Out of scope – benefit related
Modifier HU : FUNDING FROM CHILD WELF	Out of scope – benefit related
Modifier HX : FUNDED BY COUNTY AGENCY	Out of scope – benefit related
Modifier H9 : COURT ORDERED	Out of scope – benefit related
	Informational – CMS only
Modifier JA : ADMINISTERED INTRAVENOUSLY	
Modifier JB : ADMINISTERED SUBCUTANEOUSLY	Informational – CMS only
	Informational – CMS only
Modifier JC : Skin substitute used as graft	
	Informational – CMS only
Modifier JD : Skin substit not used as graft	
Modifier JW – Drug amt waste	Out of scope – pricing policy related

Attachment B-2

HCPCS Modifiers

Modifier - Modifier Definition	Edit Committee Comments
Modifier J1 : Cap no-pay submiss for RX num	Informational – CMS only
Modifier J2 : Cap restocking after emerg adm	Informational – CMS only
Modifier J3 : Cap drug NA avg sales price pd	Informational – CMS only
Modifier J4 : DMEPOS comp bid by hosp-disch	Informational – CMS only
Modifier KA : Add on Options for Wheelchair	Informational
Modifier KB : UPGR ABN, > 4 MOD IDD ON CLAIM	Informational – CMS only
Modifier KC : Repl special pwr wc intrface	Informational
Modifier KD : Drug/biological DME infused	Informational
Modifier KE : Bid round-1DMEPOS non-comp eqp	Informational – CMS only
Modifier KF : FDA class III device	Informational – CMS only
Modifier KG : DMEPOS comp bid prgm no 1	Informational – CMS only
Modifier KH : 1st Month Rent DME,Prosth,Orth	Out of scope – pricing policy related
Modifier KI : 2nd/3rd Month Rent--DMEPOS	Out of scope – pricing policy related
Modifier KJ : Months 4-15 Rent Pen Pump	Out of scope – pricing policy related
Modifier KK : DMEPOS comp bid prgm no 2	Informational – CMS only
Modifier KL : DMEPOS mail order comp bid	Informational – CMS only
Modifier KM : ReplcFacial Prosthesis-NewImpr	Informational
Modifier KN : ReplcFacial Prosthesis-PrevMst	Informational
Modifier KO : Single drug unit	Informational
Modifier KP : FIRST DRUG OF MULTI DRUG (N/A)	Informational
Modifier KQ : 2ND OR SUBQ DRUG OF MULTI(N/A)	Informational
Modifier KR : PARTIAL MO RENTAL	Out of scope – pricing policy related
Modifier KS : GLUC MON SUPP NO INSULIN TX	Out of scope – pricing policy related
Modifier KT : Item from non-contract supply	Informational – CMS only
Modifier KU : DMEPOS comp bid prgm no 3	Informational – CMS only
Modifier KV : DMEPOS Item, Profession Serv	Informational – CMS only
Modifier KW : DMEPOS Comp Bid Prgm No 4	Informational – CMS only
Modifier KX : Med policy rqmnt have been met	Out of scope – pricing policy related

Attachment B-2

HCPCS Modifiers

Modifier - Modifier Definition	Edit Committee Comments
Modifier KY : DMEPOS Comp Bid Prgm No 5	Informational – CMS only
Modifier K0 : LowerExtrem Prosthesis LVL 0	Informational – CMS only
Modifier K1 : LowerExtrem Prosthesis LVL 1	Informational – CMS only
Modifier K2 : LowerExtrem Prosthesis LVL 2	Informational – CMS only
Modifier K3 : LowerExtrem Prosthesis LVL 3	Informational – CMS only
Modifier K4 : LowerExtrem Prosthesis LVL 4	Informational – CMS only
Modifier LC : Left Circumflex Coronary Arter	Payment modifier (A) Unbundling (NCCI)
Modifier LD : Left Anterior Desc Coronary Artery	Payment modifier (A) Unbundling (NCCI)
Modifier LL : Lease/Rental--apply to Purchas	Out of scope – pricing policy related
Modifier LR : LAB ROUND TRIP (N/A)	Informational – CMS only
Modifier LS : FDA Monitor Intra Lens Implant	Informational – CMS only
Modifier LT : Left Side	Payment modifier (F) Frequency (A) Unbundling (N) Bilateral (G) Global surgery (If procedures included)?
Modifier MS : 6 Mos Maint/Svc Fee (Non-Warr)	Out of scope – pricing policy related
Modifier M2 : MEDICARE SECONDARY PAYER (MSP)	Informational
Modifier NB : Nebulizer FDA specific drug	Informational
Modifier NR : NEW EQUIP WHEN RENTED	Out of scope – pricing policy related
Modifier NU : New Equipment	Out of scope – pricing policy related
Modifier PA : Surg Proc on Wrong Body Part	Out of scope –benefit related
Modifier PB : Surg Proc on Wrong Patient	Out of scope –benefit related
Modifier PC : Wrong Surg or Proc on Patient	Out of scope –benefit related
Modifier PD : Service/IndepSite bef IP/3days	Informational
Modifier PI : PET/CT Initial Treatment	Informational – CMS only
Modifier PL : Progressive Addition Lenses	Out of scope –benefit related
Modifier PS : PET/CT Subsequent Treatment	Informational – CMS only
Modifier PT : Colon screen conv to diag test	Out of scope –benefit related
Modifier P1 : A normal, healthy patient	Payment modifier (ASA guideline) Doesn't override edits Refer to Payment Rules committee
Modifier P2 : Pt with mild systemic disease	Payment modifier (ASA guideline)

Attachment B-2

HCPCS Modifiers

Modifier - Modifier Definition	Edit Committee Comments
	Doesn't override edits Refer to Payment Rules committee
Modifier P3 : Pt has severe systemic disease	Payment modifier (ASA guideline) Doesn't override edits Refer to Payment Rules committee
Modifier P4 : Life threatening syst disease	Payment modifier (ASA guideline) Doesn't override edits Refer to Payment Rules committee
Modifier P5 : No survival without surgery	Payment modifier (ASA guideline) Doesn't override edits Refer to Payment Rules committee
Modifier P6 : Brain dead, organ donor	Payment modifier (ASA guideline) Doesn't override edits Refer to Payment Rules committee
Modifier QC : Single Channel Monitoring	Informational
Modifier QD : Digital Recording/Storage	Informational
Modifier QE : Oxygen Prescribed < 1 Liter/Mi	Payment modifier Doesn't override edits DME supplier – is this out of scope?
Modifier QF : Oxygen GT 4 Lit/Min Portable R	Payment modifier Doesn't override edits DME supplier – is this out of scope?
Modifier QG : Oxygen GT 4 Liters/Minute	Payment modifier Doesn't override edits DME supplier – is this out of scope?
Modifier QH : Oxygen System Conserving Devic	Payment modifier Doesn't override edits DME supplier – is this out of scope?
Modifier QJ –Serv/ provided to a prisoner or pt in state local custody	Informational
Modifier QK : Med Dir of 2,3,4 concur anesth	Payment modifier Doesn't override edits Refer to Payment Rules committee
Modifier QL – pt dead after amb. Called	Informational
Modifier QM : AMB SVC PROVIDER ARRANGED	Ambulance provider – is this out of scope?
Modifier QN : AMB SVC PROVIDED DIRECTLY	Ambulance provider – is this out of scope?
Modifier QP : LAB ORD AS IND TEST OR PANEL	Informational – CMS only
Modifier QS : Monitored Anesthesia Care Svc	Payment modifier Doesn't override edits Refer to Payment Rules committee
Modifier QT : RECORD/STORE ON TAPE BY ANALOG	Informational
Modifier QW : CLIA Waived Test	Out of scope – provider contract related
Modifier QX : CRNA PROV WITH PHYS SUP	Payment modifier

Attachment B-2

HCPCS Modifiers

Modifier - Modifier Definition	Edit Committee Comments
	Doesn't override edits Refer to Payment Rules committee
Modifier QY : CRNA WITH MED DIR OF ANESTH	Payment modifier Doesn't override edits Refer to Payment Rules committee
Modifier QZ : CRNA SVC; NO PHYS DIRECTION	Payment modifier Doesn't override edits Refer to Payment Rules committee
Modifier Q0 : Invest Clinical Research	Informational
Modifier Q1 : Routine Clinical Research	Informational
Modifier Q2 : HCFA/ORD Demo Proj Proc/Svc	Informational – CMS only
Modifier Q3 : FUD KIDNEY DONOR & RELTD SVCS	Informational
Modifier Q4 : Service for Refrng Phys Quals	Informational – CMS only
Modifier Q5 : SUBSTITUTE PHYS; RECIP PMT	Informational
Modifier Q6 : Svc finished by locum tenens	Informational
Modifier Q7 : One class -A- finding	Informational
Modifier Q8 : Two class -B- findings	Informational
Modifier Q9 : One class -B- and 2 -C- finding	Informational
Modifier RA : Replacement of a DME item	Informational DME item Benefit related
Modifier RB : Replace part of DME as repair	Informational DME item Benefit related
Modifier RC : Right Coronary Artery	Payment modifier (A) Unbundling (NCCI)
Modifier RD : Drug admin not incident-to	Informational – CMS only
Modifier RE : Full compliance with FDA-REMS	Informational – CMS only
Modifier RR : Rental	Informational DME item Benefit related
Modifier RT : Right Side Body Surg/Pros/Orth	Payment modifier (F) Frequency (A) Unbundling (N) Bilateral (G) Global surgery (If procedures included)?
Modifier SA : SVC BY NURSE PRACT W/ PHYS	Informational
Modifier SB : NURSE MIDWIFE	Informational
Modifier SC : MED NEC SVC OR SUPPLY	Informational
Modifier SD : Src reg nur home infus train	Informational
Modifier SE : State/Fed funded prog/svc	Informational
Modifier SF : 2ND OPINION ORDERED BY PRO	Informational

Attachment B-2

HCPCS Modifiers

Modifier - Modifier Definition	Edit Committee Comments
Modifier SG : Ambulatory Surgery Center	Out of scope – provider contract related
Modifier SH : 2nd concur admin infus ther	Out of scope – provider contract related
Modifier SJ : 3/more concur admin infus ther	Out of scope – provider contract related
Modifier SK : HIGH RISK POP FOR IMMUN	Informational
Modifier SL : STATE SUPPLIED VACCINE	Out of scope – provider contract and benefit related
Modifier SM : SECOND SURGICAL OPINION	Informational
Modifier SN : THIRD SURGICAL OPINION	Informational
Modifier SP : Accident Scene--Phys Office	Ambulance combo code
Modifier SQ : ITEM ORDERED BY HOME HEALTH	Out of scope
	Informational
Modifier SR : Accident Scene--Residence	Ambulance combo code
	Out of scope
Modifier SS : HIT infusion suite IV therapy	Out of scope – provider contract related
Modifier ST : RELATED TO TRAUMA OR INJURY	Informational
Modifier SU : PROC IN PHYS OFFICE	Informational
Modifier SW : Serv by cert diab educator	Informational
Modifier SX : Accident Scene--PhysO then Hos	Ambulance combo code
	Out of scope
Modifier SY : Contact w/high-risk pop	Informational
Modifier TA : Left Foot, Great Toe	Payment modifier (F) Frequency (A) Unbundling (N) Bilateral (G) Global surgery (If procedures included)?
Modifier TC : Technical Component	Payment modifier Can override edits: • F – Frequency edits Important to total/26/TC (M) editing When billed appropriately
Modifier TD : RN	Informational
Modifier TE : LPN/LVN	Informational
Modifier TF : Intermediate Level of Care	Informational
Modifier TG : Complex/High Tech Lev of Care	Informational
Modifier TH : Obstet Treat/Svc pre or post	Informational
Modifier TJ : Prog Gro, Child or adoles	Informational
Modifier TK : XTRA PATIENT/PASSENGER NONAMBU	Ambulance Out of scope
Modifier TL : EARLY INTERVENTION IFSP	Informational
Modifier TM : INDIV ED PRGRM (IEP)	Informational

Attachment B-2

HCPCS Modifiers

Modifier - Modifier Definition	Edit Committee Comments
Modifier TN : RURAL/OUT OF SERVICE AREA	Informational
Modifier TQ : BLS TRANSPORT; VOL AMB PROV	Informational
Modifier TR : SCH-BASED IEP SVC NOT IN DIST	Informational
Modifier TS : FOLLOW-UP SERVICE	Informational
Modifier TT : SVC PROVIDED TO > 1 PT; 1 SETT	Informational
Modifier TW : BACK-UP EQUIPMENT	Informational
Modifier T1 : Left Foot, Second Digit	Payment modifier (F) Frequency (A) Unbundling (N) Bilateral (G) Global surgery (If procedures included)?
Modifier T2 : Left Foot, Third Digit	Payment modifier (F) Frequency (A) Unbundling (N) Bilateral (G) Global surgery (If procedures included)?
Modifier T3 : Left Foot, Fourth Digit	Payment modifier (F) Frequency (A) Unbundling (N) Bilateral (G) Global surgery (If procedures included)?
Modifier T4 : Left Foot, Fifth Digit	Payment modifier (F) Frequency (A) Unbundling (N) Bilateral (G) Global surgery (If procedures included)?
Modifier T5 : Right Foot, Great Toe	Payment modifier (F) Frequency (A) Unbundling (N) Bilateral (G) Global surgery (If procedures included)?
Modifier T6 : Right Foot, Second Digit	Payment modifier (F) Frequency (A) Unbundling (N) Bilateral (G) Global surgery (If procedures included)?
Modifier T7 : Right Foot, Third Digit	Payment modifier (F) Frequency (A) Unbundling (N) Bilateral (G) Global surgery (If procedures included)?
Modifier T8 : Right Foot, Fourth Digit	Payment modifier (F) Frequency (A) Unbundling (N) Bilateral (G) Global surgery (If procedures included)?
Modifier T9 : Right Foot, Fifth Digit	Payment modifier (F) Frequency

Attachment B-2

HCPCS Modifiers

Modifier - Modifier Definition	Edit Committee Comments
	(A) Unbundling (N) Bilateral (G) Global surgery (If procedures included)?
Modifier UA : HCBS - MI WAIVER	Informational
Modifier UB : INVOICE COST	Informational
Modifier UC : HCBS-CDCE Waiver	Informational
Modifier UD : HCBS-Pediatric Hospice Waiver	Informational
Modifier UE : Used DME	Out of scope DME
Modifier UF : SVCS IN THE MORNING	Informational
Modifier UG : SVCS IN AFTERNOON	Informational
Modifier UH : SVCS IN EVENING	Informational
Modifier UI : Unclassified to Transfer Site	Informational
Modifier UJ : SVCS AT NIGHT	Informational
Modifier UK : SVCS TO OTHER THAN CLIENT	Informational
Modifier UL : HCBS - CWA WAIVER	Informational
Modifier UN : Unclassified to SNF	Informational
Modifier UP : Unclassified to Physician Offc	Informational
Modifier UR : Unclassified to Residence	Informational
Modifier US : Unclassified to Accident Scene	Informational
Modifier U1 : HCBS - EBD WAIVER	Informational
Modifier U2 : HCBS - PLWA WAIVER	Informational
Modifier U3 : HCBS - DD WAIVER	Informational
Modifier U4 : TARGETED CASE MANAGEMENT (TCM)	Informational
Modifier U5 : CHILDRENS HCBS WAIVER (CHCBS)	Informational
Modifier U6 : HCBS - BI WAIVER	Informational
Modifier U7 : HCBS - CS WAIVER	Informational
Modifier U8 : HCBS - SLS WAIVER	Informational
Modifier U9 : HCBS - CHRP WAIVER	Informational
Modifier VP : Aphakic Patient	Informational
Modifier V5 : Vascular Catheter	Informational
Modifier V6 : Arteriovenous Graft	Informational
Modifier V7 : Arteriovenous Fistula	Informational
Modifier V8 : Infection Present	Deleted
Modifier V9 : No Infection Present	Deletedl
Modifier V9 : No Infection Present	Informational

Attachment C

Colorado Task Force - Edit Committee Specification/Query criteria

Topic	Definition	Query	Comment
Asst. Surgeon	<p>1) Start with ACS recommendations and accept either Always or Never; if sometimes or silent - go to CMS -and take Always or Never; if sometimes -- default to Never</p> <p>2) modifiers 80, 81, 82, AS</p> <p>3) quarterly update</p>	CPT code, Indicator - A, N, S, Source, type of edit, from and through effective dates, create historical trail	think about how to incorporate modifiers where to put the final list?
Co Surgeon	<p>1) This type of edit will identify when consideration for payment will be made to two surgeons reporting that they were the primary surgeon when performing a distinct part(s) of a single surgical procedure.</p> <p>2) Modifier 62</p> <p>3) quarterly update</p>	CPT code, Indicator -(Y, N, N/A) Source, type of edit, from and through effective dates, create historical trail	limit to only surgical procedures
Team Surgery	<p>1) This type of edit will identify when consideration for payment will be made when a complex surgical procedure requires several physicians to act as a primary surgeon when performing a distinct part(s) of a single surgical procedure.</p> <p>2) Modifier 66</p>	CPT code, Indicator - (Y, N, N/A) Source, type of edit, from and through effective dates, create historical trail	limit to only surgical procedures use CMS list, if not on list and modifier 66 is billed then deny

Age	1) This type of edit will identify incorrect billing of a professional service when the CPT/HCPCS descriptor of the service/procedure code or the related coding guideline implies age-specific parameters.	CPT code, Indicators - (minimum age/maximum age) values reflected in months, Source, type of edit, from and through effective dates, create historical trail	1) do we standardize how we count in days, months, years --- we agree it should be reported in months - convert to years 2) do we need to standardize whether it is through the year of the age (i.e. Age range goes to 18 -- goes through until their 19th birthday) 3) do we need to build in added time for exceptions? or do you just handle it on appeal? build edits based on code - allow payers to handle exceptions individually
Gender	1) This type of edit will identify incorrect billing of a professional service when the CPT/HCPCS descriptor of service/procedure code implies gender-specific parameters.	CPT code, Indicators - (Male, Female, Unknown?) Source, type of edit, from and through effective dates, create historical trail	final list may include those codes that are N/A
Max Freq/Per Day	This type of edit will identify incorrect billing of a professional service when the CPT/HCPCS descriptor of the service/procedure code, or the related coding guidelines imply restrictions on the number of times the service/procedure can be provided on a single calendar date.	CPT code, Indicators - (numerical limit) Source, type of edit, from and through effective dates, create historical trail	start with MUE and customize to meet the definition - like the derm codes

Attachment D

Data Sustaining Repository Committee Proposed Amendments to the Edit/Rule Development and Adoption Process

(as of February 7, 2013)

NOTE: Items in **red** are changes recommended by the DSR Committee. Items in **green** are changes recommended by the executive committee and facilitator for consideration to clarify certain points.

Task Force Process for Developing a Standardized Set of Claims Edits and Payment Rules

January 24, 2012

The task force adopted the following decision rule for selecting, adding, deleting, modifying and reconciling conflicting edits:

The Context

The task force is responsible for developing a standardized set of payment rules and claim edits to be used by all payers. In developing the standardized set, the task force shall consider standardizing a list of types of edits listed in the act. The base set of rules and edits shall be identified through existing national industry sources.

Creating an Initial Draft of the Complete Edit Set

- a. For the types of edits listed in the act, develop definitions, including purpose, rationale and guiding principles.
- b. Identify all available national sources¹ and third-party vendor edits that: are relevant to the edit/rule being developed; are in a machine-readable format to be determined; are not benefit-related (e.g., Medicare G codes); and come from national sources or are sourced to a national source. The edit/rule shall not set a price for services or determine medical necessity.
- c. For a given edit, if there is only one national industry source with a definitive edit that fits the definition/rationale **then, subject to the results of the Data Analysis described in the next section**, use that edit.
- d. If there are multiple national sources (e.g., HCPCS and a national medical specialty society (NMSS)) for the same definitive edit (e.g., age), and if all are consistent with the definition/rationale for the edit under consideration, and if the edit is not benefit-related, then establish and use a hierarchy agreed upon by the Task Force for each edit (e.g., CPT®, then NMSS, HCPCS, then NCCI, etc.).
- e. For a given edit, if there is no definitive national source edit and if there is only one third-party that has done sourcing for that edit and if the third party edit fits the definition/rationale, then

include the edit in the initial draft of the complete set.

- f. For all other edits , where there is multiple sourcing for the same edit, select edits to get to the initial draft of the complete set using the national hierarchy approach described above to select among edits developed through third-party sourcing (e.g., for edits developed through sourcing, start with edits based on CPT® materials, then NMSS, etc.)

Data Analysis

- a. Ensure that all valid source material is part of the data analysis.
- b. Complete an integrity analysis in one or more sources to cover:
 - 1) Consistency internally, with the rational and guidelines, and among the choices.
 - 2) Accuracy both in clinical and operational (i.e., technical feasibility to implement the rule) dimensions, and
 - 3) Completeness. If not complete, find a way to make complete or improve on the source.
- c. Prioritize multiple source material based on consistency, accuracy and completeness, as noted above.
- d. Conduct an impact analysis of the draft rule set (i.e., a feasibility assessment—can this be implemented, will it be costly for payers to implement, etc.).

Public Comment on, Review and Refinement of, Finalizing and Publishing the Initial, Complete Edit Set

- a. Establish a timeline for implementation.ⁱⁱ
- b. Make the draft initial set available for testing, review and comment by vendors, payers, providers and others. Make it possible for interested parties, including the task force itself, to run various scenarios against the initial draft complete edit set.
- c. Require recommendations from the public (including national medical specialty societies) for additions, deletions, and modifications to the initial draft complete set to be based on one of the following; the change better fits the definition/rationale; an edit does not work for a commercial population; the original source for an edit objects to how sourcing by a third party was done; or an edit is altogether missing from, but does not duplicate an edit, in the set.
- d. After considering comments and recommendations from the public and weighing the results of the task force’s own modeling and testing, finalize the initial complete edit set.
- e. Utilize a process based on the Colorado Rule Making Procedure, CRS 24-4-103, which includes notification of interested parties.
- f. Identify any existing communication mechanisms that can be utilized to forward the “official” state notification to the provider, payer and vendor community.

- g. The results of reconsiderations should be published at the time the final rule is published and kept on file for future use in responding to inquiries.
- h. Make the rationale available

Updating the Complete Set after It Has Been Established by the Task Force

- a. Ensure that all valid source material is part of the DSR.
- b. Direct the DSR manager to update, on a quarterly basis, those edits straightforward enough that they can be handled as part of quarterly maintenance (e.g., if an initial set of A-P edits comes from a national industry source and the source updates its edit set, the Colorado complete set of edits will be updated accordingly) **using the decision rule process outlined above..**
- c. Convene a panel (structure to be determined) to:
 - 1) Add or delete edits not straightforward enough to be handled as part of quarterly maintenance (e.g., an alternative edit becomes available from a new source and it must be determined whether the new edit or the existing edit in the DSR library should be included in the library).
 - 2) Maintain an open public process for:
 - a) Edits that could not be handled by the panel;
 - b) Resolution of concerns brought to the panel; and
 - c) Changes to some element of the Decision Rule (e.g., change in the hierarchy of national sources for an edit set).
 - d) The results of any changes that result from a request from an interested party should be documented and shared with the requesting party.

Final Approval

Performed according to by laws of Full Task Force

If conflict exists from stakeholder, must provide rationale (e.g. if issue is on balance a pricing vs. coding one, then err on the side of coding rationale.

ⁱ At its December 28, 2011, meeting the Task Force adopted the following definition: “Sources” means the list of national industry sources found in §(2)(b)(I-VII),C.R.S., of HB10-1332 only: (I) the NCCI; (II) CMS directives, manuals and transmittals; (III) the CMS national clinical laboratory fee schedule; (V) the HCPCS coding system and directives; (VI) the CPT coding guidelines and conventions; and (VII) national medical specialty society coding guidelines. The Task Force adopted the following definition of “national medical specialty society:” national medical organizations that are assigned as advisors to, or are represented on, AMA, CPT, and AMA Health Care Professionals Advisory Committee (HCPAC) that includes organizations representing limited license practitioners and other allied health professionals.

ii The July 9, 2012, Clean Claims Task Force Work Plan included the following timeline:

Month 1	Proposed edit set published for review. Interested parties have an opportunity to run their claims through the proposed set.
Month 3	Comments due on proposed set.
Month 3	Begin process of reviewing comments and task force /committee recommending changes to edit set based on public comment.
Month 5	Task force reviews and finalizes complete set
Month 5	Consultant begins draft of RFP for DSR operator.
Month 6	Co-chairs review and approve draft and RFP is issued.
Month 7	RFP proposals due. Consultant begins review and analysis of RFP responses. Bidders meeting minimum RFP requirements are interviewed.
Month 8	Task force reviews and approves selection of DSR operator.
Months 9-14	DSR operator contract signed. Operator updates edit set to reflect updates to sources as needed. Payers begin process of conforming their systems to Colorado edit set.
Jan. 1, 2016 —Month 15	Latest date commercial payers must begin using the edit set.



Attachment E

HB 10-332 Colorado Medical Clean Claims Transparency & Uniformity Task Force

Subgroup Recommendation

Topic	Assistant at surgery
Date	4/25/12
Subgroup	Edit Sub-Committee
Issue (1-2 sentences)	<p>In order to develop the assistant surgery definition to be used as part of the standard edit set, the Edit Committee has reviewed the publically available listings that identify which CPT procedure codes are eligible for an assistant at surgery. Two such lists are published, one by the American College of Surgeons (ACS) and the other by the Centers for Medicare and Medicaid Services (CMS). The lists are not identical.</p>
RECOMMENDATION	<p>The following decision tree is recommended to reconcile the differences between the two lists and develop a standardized assistant surgery listing:</p> <ol style="list-style-type: none"> 1) If the ACS indicator for assistant surgery is ALWAYS or NEVER we will accept the ACS edit as our edit. 2) If the ACS indicator is SOMETIMES and the CMS data set is ALWAYS or NEVER we will accept the CMS edit as our edit. 3) If both the ACS and CMS indicators are SOMETIMES, then we will default our edit to NEVER. <p>ANY ASSISTANT SURGERY DENIAL IS APPEALABLE BASED ON MEDICAL NECESSITY.</p>
Reason/basis for recommendation (3-5 sentences)	<p>As part of the promise of HB 10-1332 was administrative simplification, the Edit Sub-Committee recommends that the the assistant surgery decision should initially always be a yes or no, rather than indicating that the SOMETIMES indicators of the source listings be PENDED for review of the medical necessity in our data set.</p> <p>There was a concern that changing the SOMETIMES to an automatic ALWAYS could have an adverse financial impact on the payers and compromise the acceptability of the Task Force’s standardized edit set by the industry.</p>
TASK FORCE DECISION & DATE	Adopted 5/23/12

Colorado Clean Claim Task Force

Edit Committee

Assistant at Surgery Payment Rule Recommendation

Co-chairs

Beth Wright, WellPoint, Inc.

Mark Painter, PRS Network

Modifier(s) Involved

80 – Assistant Surgeon: surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

81 – Minimum assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

82 – Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for the use of modifier 82 appended to the usual procedure code number(s)

Primary Recommendation

Combination of the American College of Surgeon's Assistant at Surgery Recommendation and the CMS Assistant at Surgery Rule.

Assistant at Surgery payment rule hierarchy:

- If the ACS indicator for assistant surgery is ALWAYS (ACS category Almost Always) or NEVER (ACS category Almost Never) we will accept that as our edit.
- If the ACS indicator is SOMETIMES or SILENT (as in the case of a new CPT code) and the CMS data set is ALWAYS (CMS indicator 2) or NEVER (CMS indicator 9) we will accept that as our edit.
- If both the ACS and CMS indicators are SOMETIMES (ACS category Sometimes, CMS indicator 1), then we will default our edit to NEVER.

Those procedures with indicator NEVER would either be denied with request for supporting documentation to support medical necessity or an agreement could be reached between the payer and provider to submit supporting documentation to support medical necessity with the original claim submission. A special notation is included for all rules that indicate the physician or other healthcare provider's right to appeal any decision based on medical necessity with supporting documentation.

Note: Edits will be updated quarterly based on information presented or upon change of the base data set. The intention of the rule is to base primary computer adjudication on best available clinical information as it relates to the majority of claims. The ability to appeal is retained to allow for specific circumstances as it is recognized that all rules are applicable to all cases.

American College of Surgeon's Assistant at Surgery Recommendation

Assistant at Surgery Categories

Almost always (*Classified as ALWAYS in recommendation*)

Sometimes (*Classified as **SOMETIMES** in recommendation*)

Almost never (*Classified as **NEVER** in recommendation*) (*Affects approximately 500 procedures*)

Center for Medicare and Medicaid Services

Assistant at Surgery Status Indicators

0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity. (*Classified as **SOMETIMES** in recommendation*)

1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid. (*Classified as **SOMETIMES** in recommendation*)

2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid. (*Classified as **ALWAYS** in recommendation*)

9 = Concept does not apply. (*Classified as **NEVER** in recommendation*)

Secondary Recommendation

Default to CMS Assistant at Surgery Rule

Federation outreach

American College of Orthopaedic Surgeons (AAOS)

Reached out to Matt Tweeten of AAOS for review. A response is expected before February 26, 2013.

American College of Surgeons (ACS)

Reached out to Jenny Jackson of ACS for review. She expressed concerns and is currently outlining those concerns in a formal letter to the CCCTF. This letter is expected before February 26, 2013.

ATTACHMENT.G

2013 Task Force Meeting Schedule, All Task Force Meeting Times are MST (Mountain Standard Time)

January 23, noon – 2 pm: Full Task Force Meeting

February 27, 8 am – 3:30 pm: Full Task Force Quarterly Meeting

March 27, noon – 2 pm: Full Task Force Meeting

April 24, noon – 2 pm: Full Task Force Meeting

May 22, 8 am – 3:30 pm: Full Task Force Quarterly Meeting

June 26, noon – 2 pm: Full Task Force Meeting

July 24, noon – 2 pm: Full Task Force Meeting

August 28, 8 am – 3:30 pm: Full Task Force Quarterly Meeting

September 25, noon – 2 pm: Full Task Force Meeting

October 23, noon – 2 pm: Full Task Force Meeting

November 27 - regularly scheduled day following day is Thanksgiving

December 25 – regularly scheduled meeting on Christmas