January 25, 2013

Dear Provider:

The Health Care District of Palm Beach County has identified an increase in claims submitted with omitted or incorrect modifiers. In an effort to correct this problem, we request the review of the included attachment which addresses the most frequent incorrect use of modifiers. Additionally, to expedite the processing of claims correctly submitted, those submitted with an omitted or incorrect modifier will be processed and denied. Should the provider decide to resubmit these denied claims, please submit the claim as a corrected claim. Timely filing standards will remain in effect.

Thank you for your continued participation in the Health Care District network and for the care that you provide to the Health Care District members. Should you have any questions regarding this letter, please contact the Customer Service Department at 866-930-0035 toll free in Palm Beach County or 561-659-0035.

Sincerely,

Claims Department

The following information will give you a better understanding of the most frequent incorrect use of modifiers and how to eliminate these errors. The District utilizes the National Part B Billing and Payment Guide which is available through Decision Health at www.decisionhealth.com. Please become familiar with this information, make sure that you are billing the modifiers correctly, and document the conditions in the medical record that support the use of the modifiers.

Bilateral Procedure (Modifier 50)
It has been identified that providers are not utilizing or incorrectly utilizing this code.

Please remember to incorporate the following guidelines in your billing process:

- Use modifier 50 for surgical procedures.
- Use modifier 50 to describe procedures performed on both sides of the body (mirror image) at the same session.
- Use modifier 50 on bilateral body organs, such as the kidneys, ureters and hands.
- Do not append modifier 50 when the code descriptor indicates bilateral.
- Do not append modifier 50 when the code descriptor indicates unilateral or bilateral.
- Do not append modifier 50 to procedures on the skin because the skin is one organ.
- Use modifier 52, Reduced Services, when a procedure descriptor indicates a bilateral procedure and is performed unilaterally. Use RT or LT to indicate the surgical site when appropriate.
- Append the modifier to the appropriate code as a 1-line entry. Reporting the unilateral code with modifier 50 appended to the CPT code as a 1-line entry on the claim form indicates the procedure was performed bilaterally. Refrain from repeating a code and appending modifier 50 to the code on the second line of the claim form.
- For the billing of procedures with a payment indicator of 1, use modifier 50.
- For the billing of radiological procedures with a payment indicator of 3, use HCPCS level II RT and LT designations.
- The National Correct Coding Initiatives are violated if bilateral procedures are broken out and coded individually when the descriptor of the code indicates they are bilateral.

Payment is calculated by multiplying 150% of the unit value times the conversion factor. If the code is reported as a bilateral procedure, and is reported with other procedure codes on the same day, then the bilateral adjustment will be applied

before applying any multiple procedure rules. (Per Medicare guidelines, bilateral procedures should be billed as one line item, with modifier 50 appended, and as one unit of service.)

A bilateral procedure billed with another procedure is priced as follows:
Multiply the assigned unit value of the bilateral procedure times 150%

- The procedure with the greatest unit value is the primary surgery.
- The procedure with the lesser unit value is the secondary surgery.
  - If the bilateral procedure is the lesser valued procedure it is considered the secondary procedure and is priced at 50% of 150% (which is equivalent to 75%.)

For assistance in determining if a procedure is considered bilateral and whether it is eligible for reimbursement, consult the Medicare Physician Fee Schedule @www.cms.gov/apps/physician-fee-schedule.

Multiple Procedures (Modifier 51)
It has been determined that providers are omitting the use of modifier 51 when they are not appending this modifier to the additional procedure or service codes performed at the same session by the same provider.

Please remember to incorporate the following guidelines in your billing process:

- Use modifier 51 to report same procedure but different site.
- Use modifier 51 when multiple procedures are performed on the same day at the same operative session.
- Use modifier 51 to indicate a procedure performed multiple times.
- List the major procedure code first. This code is reported without a modifier. The major procedure code is the one with the highest relative value units. Next, list the additional lesser procedures as secondary with modifier 51.
- Multiple endoscopy payment rules apply if the procedure is billed with another endoscopy in the same family. The same rule is true for laparoscopies and arthroscopies.
- Do not append modifier 51 to add-on codes.
- Do not append modifier 51 to modifier 51-exempt procedure codes.
- For billing the delivery of twins, you may report the appropriate CPT code with modifier 51 appended to the second procedure.

Distinct Procedural Service (Modifier 59)
It has been identified that once providers receive a denial stating the service is included with another procedure, providers are then using the modifier 59 every time they bill for that service. Use of this modifier incorrectly will not result in bypassing the bundling edits.

The National Correct Coding Initiative (NCCI) edits for "bundling" are not the only reason codes are denied. Program coverage such as global surgery, radiation therapy, and even physician payment reform may result in bundling denials.

Please remember to incorporate the following guidelines in your billing process:

- Use modifier 59 to indicate a different session or encounter.
- Use modifier 59 to indicate a different procedure.
- Use modifier 59 to indicate a different site.
- Use modifier 59 to indicate a separate incision, excision, lesion, injury or body part.
- Use modifier 59 to report distinct and separate procedures performed on the same day.
- Modifier 59 should be used with great caution because it affects reimbursement and indicates that, under distinct circumstances, it is appropriate to bill procedures as separate and distinct. This modifier is not designed to provide reimbursement for separate procedures that are performed as an integral part of another procedure and is monitored closely.
- When a procedure in the CPT code descriptor is described as a separate procedure code but is carried out independently or is unrelated to other services performed at the same session, the CPT code may be reported with modifier 59.
- Modifier 59 should not be appended when another more descriptive modifier is available.
- The documentation in the medical record must be specific to the distinct procedure and clearly identifiable.
- Modifier 59, when used appropriately, allows the CPT code to bypass edits with the NCCI when claims are denied for unbundling.
- Check the NCCI edits when reporting procedures with modifier 59.

Assistant Surgeon (Modifier 80)

It has been determined that providers are billing as the primary surgeon and then rebilling as the assistant surgeon.

Please remember to incorporate the following guidelines in your billing process:

- Modifier 80 is used when a surgical assistant is used for the entire procedure to assist the primary surgeon.
- Payment is not allowed for an assistant when the assistant is a non-licensed physician or a non-physician in the operating room (surgical technician).
- Assistant surgeons are required to bill under their own name even when they are in the same practice as the primary surgeon.

- The operative note must clearly document what the assistant surgeon did during the operative session.
- To determine if a surgical procedure is approved for the use of an assistant at surgery, refer to the Medicare Physician Fee Schedule Database (MPFSDB).
- Use modifier 62 or 66 if the procedure requires the use of co-surgeons or a team of surgeons.
- Other modifiers may be used, if applicable, when modifier 80 is appended.