When to Apply Modifiers

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Part 8

In part 7 of this article we discussed modifiers that may be applied when a service is rendered in a particular location (rural area, Health Professional Shortage Area (AQ) and teaching facility (GC)).

Some procedures (Radiology, Stress Tests, Cardiac Cath, etc.) can be divided into a professional only component (performed by the physician) and a technical only component (facility). Below are situations that you might encounter when a procedure is performed in a hospital setting which may necessitate the addition of the technical component (TC) modifier or the professional component modifier (26).

The payment for the technical component portion of a test includes the practice expense and the malpractice expense. Technical component procedures are institutional and cannot be billed separately by the physician when the patient is an inpatient, outpatient, or in a covered Part A stay in a skilled nursing facility (SNF) location.

Note: Modifiers 26 and TC are considered payment modifiers.

Modifier 26 – Professional Component

Modifier 26 is used to describe the portion of the service that is performed by a physician. If the physician owns the x-ray machine, buys the supplies and pays the personnel in addition to reading the x-ray, modifier 26 would not be used.

The professional component (26) includes:

The physician's work in providing the services (e.g., reading films, interpreting diagnostic tests, etc.); and

Interpretation and written report provided by the physician performing the service.

(Continued on page 2)
When to Apply Modifiers *(continued from page 1)*

**Append**

- When the provider utilizes equipment owned by a hospital/facility.
- When the provider’s interpretation is separate, distinct, written and signed.

**Do Not Use When**

- The same provider performs both the technical and professional components, unless the same provider reports both components and the technical portion is purchased.
- Reporting it for re-read results of an interpretation provided by another physician.
- Appending it to technical only procedure codes and global test only codes.
- The description of the CPT code indicates the professional component only or the technical component only. No Modifiers would be appended to these codes. For example, a facility performs a 12 lead EKG and has an independent physician read the strip: 93005 Tracing only (facility) and 93010 Interpretation and report only (physician).

**Example**

A patient has a PA and lateral for suspected pneumonia in the physician’s office by a technician. The physician interprets the chest X-ray and dictates a report.

**Answer**

71020 would be reported because the physician pays the tech’s salary and owns the equipment and therefore bills under the global code which includes both the professional (26) and technical components (TC)

**Reimbursement***

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>71020</td>
<td></td>
<td>$31.17</td>
</tr>
<tr>
<td>71020</td>
<td>26</td>
<td>$11.11</td>
</tr>
<tr>
<td>71020</td>
<td>TC</td>
<td>$20.06</td>
</tr>
</tbody>
</table>

*Based on National payment amount 2014


(Continued on page 3)
When to Apply Modifiers (continued from page 2)

Example
Polysomnography, is performed at a Certified Sleep Center on a 26 YO patient. A physician not associated with the sleep center interprets the findings.

Answer
The physician reports the polysomnography interpretation as 95811-26, the professional component.
The sleep center reports 95811-TC, the technical component.

Modifier TC – Technical Component
This modifier identifies the technical component of certain services that combine both the professional and technical portions in one procedure code. Using modifier TC identifies the technical component. The technical component (TC) includes providing the equipment, supplies and technical personnel.

Append
- When billing for the technical component of a test.
- Used when billing both the professional and technical component of a procedure when the technical component was purchased from an outside entity. The provider would bill the professional on one line of service and the technical on a separate line.

Do Not Use When
- The physician performs both the professional and technical components on the same day.
- Appending it to technical only procedure codes or global test only codes.
- The description of the CPT code indicates the professional component only or the technical component only. No Modifiers would be appended to these codes.

Example
A 5 YO boy with an implanted programmable CSF valve and shunt system, is referred by a pediatrician for recent onset of constant complaints of headache. His history includes implantation of the shunt 3 years prior for hydrocephalus. After reviewing the patient chart and previous films, and evaluating the patient in the office, the surgeon decides to decrease the shunt pressure. The surgeon orders a radiograph to determine the current setting of the shunt valve. After reviewing the results of the radiograph, the physician reprograms the shunt from 120 mm H₂O to 80 mmH₂O. This is done in the radiology department. After confirming the pressure setting, the patient is released from radiology department. The surgeon dictates a written interpretation report and a follow-up phone call to the boy's family several days later finds that a headache has not occurred since the reprogramming. The written report is sent to the referring pediatrician.

(Continued on page 4)
When to Apply Modifiers (continued from page 3)

Answer

- CPT Code billed by the Surgeon: 62252-26 - Reprogramming of programmable cerebrospinal shunt
- CPT Code billed by Radiology Department: 62252-TC

Reimbursement*

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
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<td>62252</td>
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<td>62252</td>
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<tr>
<td>62252</td>
<td>TC</td>
<td>$39.05</td>
</tr>
</tbody>
</table>

*Based on National payment amount 2014


To be continued in the next issue.

Transition to ICD-10

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What is the industry expecting will happen with the ICD-10 Transition?

1. Claim rejections are expected to rise either due to coding errors or lack of documentation by the provider for the coder to be able to code for the encounter. Therefore, providers should be educated on how to document on very specific things such as acute, chronic, right and left, initial, subsequent and sequelae. The utilization of unspecified codes will lead to denials and or requests for additional information by the payers which of course will hold up claim payment.

2. Transition to ICD-10 will also affect productivity. It is expected that it will take longer to code each encounter due to the number of codes that will be required and new criteria. Data and charge entry will also take longer because the new codes are both alpha and numeric requiring more than just utilization of the key pad. Encounter forms which used to be a great tool utilized by the provider will now be obsolete due to the specificity of each code.

Therefore, we must strive to educate current provider and coding staff in order to lessen the effect on productivity and make the recovery phase post the October 1st implementation a success.
MiraMed Philippines Adds More Feathers to Its Certification Cap

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Senior Manager, Training Department
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MiraMed Philippines (MMP) recently added the American Academy of Professional Coders (AAPC) certification, specifically the CPC-A and CPC-H-A exams to its string of certification portfolio. MMP recently sent experienced medical coders to take the exams for CPC-H-A and CPC-A. CPC-H-A certification is Certified Professional Coder-Hospital-Apprentice. AAPC notes that “the CPC-H® exam validates the specialized payment knowledge needed for medical coding jobs in addition to CPT®, ICD-9, and HCPCS Level II coding skills.” AAPC further states that “AAPC’s Certified Professional Coder (CPC®) credential is the gold standard for medical coding in physician office settings and held by nearly 98,000 coding professionals.”

Of the 56 coders who took the CPC-H-A exam, MMP successfully scored a 100% passing rate. On the other hand, of the 87 coders that took the CPC-A, 80 passed with a 92% passing rate. Overall, MiraMed Philippines’ passing average was a high 95% with an acknowledgment from an AAPC official that “MiraMed has done exceptionally well in the AAPC exams.”

MiraMed’s Philippines Education Team has developed competitive, dynamic and fully-integrated training programs and reviews for the medical coders. The education team stresses that the key to excellence in education is to be able to bring out the best in each of their students and ensures that after the training and quality education sessions, the medical coders will be more equipped not only in passing certification and accreditation exams but also in maintaining high quality services that MMP commits to deliver to its clients when and where these are needed.

MiraMed Philippines continues to be the competitive advantage in healthcare industry.

(Continued on page 3)
It is our mission to grow and improve this newsletter with each issue. In order to accomplish this goal we need your help! Your input is extremely valuable. Please take a moment to answer the following:

- Tell us what you would like to see in future publications.
- What types of articles would be most beneficial?
- Has this newsletter been of value to you?
- Would you be interested in submitting an article for publication?

You may send your responses via e-mail to kim.capello@miramedgs.com.

The will to win, the desire to succeed, the urge to reach your full potential... these are the keys that will unlock the door to personal excellence.

Confucius
Revised ICD-10-CM Guidelines FY 2015 Released by CMS

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Recently, the Centers for Medicare & Medicaid Services (CMS) issued changes on ICD-10-CM guidelines. The following are some of the modifications that have been made:

Note:

Fonts in Orange are the Revised Statements
Fonts in Blue are Additional Statement
Fonts with STRIKETROUGH are deleted Statements

**Section I.B.10: Sequela (late effects)**

A sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a sequela code can be used. The residual may be apparent early, such as in cerebral infarction, or it may occur months or years later, such as that due to a previous injury. **Examples of sequela include**: scar formation resulting from a burn, deviated septum due to a nasal fracture, and infertility due to tubal occlusion from old tuberculosis. Coding of sequela generally requires two codes sequenced in the following order: the condition or nature of the sequel is sequenced first, and the sequela code is sequenced second.

**Section I.C.1.b.5.c: Postprocedural Infection and Postprocedural Septic Shock**

In cases where a postprocedural infection has occurred and has resulted in severe sepsis the code for the precipitating complication such as code T81.4, Infection following a procedure, or O86.0, Infection of obstetrical surgical wound should be coded first followed by code R65.20, Severe sepsis without septic shock. A code for the systemic infection should also be assigned.

If a postprocedural infection has resulted in postprocedural septic shock, the code for the precipitating complication such as code T81.4, Infection following a procedure, or O86.0, Infection of obstetrical surgical wound should be coded first followed by code T81.12-, Postprocedural septic shock. A code for the systemic infection should also be assigned.

**I.C.13.c., Coding of Pathologic Fractures**

7th character A is for use as long as the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, evaluation and continuing treatment by the same or a different physician. While the patient may be seen by a new or different provider over the course of treatment for a pathological fracture, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

(Continued on page 8)
I.C.19.19.a, Injury, Poisoning, and Certain Other Consequences of External Causes

Most categories in chapter 19 have a 7th character requirement for each applicable code. Most categories in this chapter have three 7th character values (with the exception of fractures): A, initial encounter, D, subsequent encounter and S, sequela. Categories for traumatic fractures have additional 7th character values. While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

For complication codes, active treatment refers to treatment for the condition described by the code, even though it may be related to an earlier precipitating problem. For example, code T84.50XA, Infection and inflammatory reaction due to unspecified internal joint prosthesis, initial encounter, is used when active treatment is provided for the infection, even though the condition relates to the prosthetic device, implant or graft that was placed at a previous encounter. ICD-10-CM Official Guidelines for Coding and Reporting FY 2015

7th character “A”, initial encounter is used while the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and continuing treatment by the same or a different physician.

7th character “D” subsequent encounter is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Examples of subsequent care are: cast change or removal, an x-ray to check healing status of fracture, removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following treatment of the injury or condition.

I.C.19.19.c.1, Initial vs. Subsequent Encounter for Fractures

Traumatic fractures are coded using the appropriate 7th character for initial encounter (A, B, C) while the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and continuing (ongoing) treatment by the same or different physician. The appropriate 7th character for initial encounter should also be assigned for a patient who delayed seeking treatment for the fracture or nonunion.

Fractures are coded using the appropriate 7th character for subsequent care for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase. Examples of fracture aftercare are: cast change or removal, an x-ray to check healing status of fracture, removal of external or internal fixation device, medication adjustment and follow-up visits following fracture treatment.

I.C.20.a.2, External cause code used for length of treatment

Assign the external cause code, with the appropriate 7th character (initial encounter, subsequent encounter or sequela) for each encounter for which the injury or condition is being treated.
Revised ICD-10-CM Guidelines FY 2015 Released by CMS (continued from page 8)

Most categories in chapter 20 have a 7th character requirement for each applicable code. Most categories in this chapter have three 7th character values: A, initial encounter; D, subsequent encounter; and S, sequela. While the patient may be seen by a new or different provider over the course of treatment for an injury or condition, assignment of the 7th character for external cause should match the 7th character of the code assigned for the associated injury or condition for the encounter.

I.C.20.b, Place of Occurrence Guideline

Codes from category Y92, Place of occurrence of the external cause, are secondary codes for use after other external cause codes to identify the location of the patient at the time of injury or other condition.

Generally, a place of occurrence code is assigned only once, at the initial encounter for treatment. However, in the rare instance that a new injury occurs during hospitalization, an additional place of occurrence code may be assigned. No 7th characters are used for Y92.

Do not use place of occurrence code Y92.9 if the place is not stated or is not applicable.

I.C.20.d, Place of Occurrence, Activity, and Status Codes Used with other External Cause Code

When applicable, place of occurrence, activity, and external cause status codes are sequenced after the main external cause code(s). Regardless of the number of external cause codes assigned, generally there should be only one place of occurrence code, one activity code, and one external cause status code assigned to an encounter. However, in the rare instance that a new injury occurs during hospitalization, an additional place of occurrence code may be assigned.

I.C.21.c.16, Z Codes That May Only be Principal/First-Listed Diagnosis

The following Z codes/categories may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined:

Z00 Encounter for general examination without complaint, suspected or reported diagnosis. Except: Z00.6

II.E, A Symptom(s) Followed by Contrasting/Comparative Diagnoses

When a symptom(s) is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. However, if the symptom code is integral to the conditions listed, no code for the symptom is reported. All the contrasting/comparative diagnoses should be coded as additional diagnoses. (Deleted effective Oct. 1, 2014.)

## Brush Up On Medical Terminology

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### INTEGUMENTARY SYSTEM

<table>
<thead>
<tr>
<th>Term</th>
<th>Word Origin</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cyst</td>
<td>cyst/o sac, bladder</td>
<td>Nodule filled with a semisolid material, such as a keratinous or sebaceous cyst</td>
</tr>
<tr>
<td>Ecchymosis</td>
<td>ec- out hym/o juice -osis abnormal condition</td>
<td>Hemorrhage or leaking of blood into the subcutaneous tissue</td>
</tr>
<tr>
<td>Hematoma</td>
<td>hemat/o blood -oma mass, tumor</td>
<td>Collection of blood outside of a blood vessel</td>
</tr>
<tr>
<td>Macule</td>
<td>macul/o spot -ule small</td>
<td>Flat blemish or discoloration less than 1 cm, such as a freckle, port-wine stain, or tattoo</td>
</tr>
<tr>
<td>Nodule</td>
<td>nod/o knot -ule small</td>
<td>Palpable, solid lesion less than 2 cm</td>
</tr>
<tr>
<td>Papule</td>
<td>papul/o pimple -ule small</td>
<td>A solid, rounded growth that is elevated from the skin, usually less than 1 cm</td>
</tr>
<tr>
<td>Pustule</td>
<td>pustul/o pustule -ule small</td>
<td>Superficial, elevated lesion containing pus that may be the result of infection</td>
</tr>
<tr>
<td>Vesicle</td>
<td>vesicul/o blister or small sac</td>
<td>Circumscribed, elevated lesion containing fluid and smaller than 1/2 cm</td>
</tr>
<tr>
<td>Eschar</td>
<td>eschar/o scab</td>
<td>The scab formed when a wound or skin is sealed by the heat of cautery or burning</td>
</tr>
<tr>
<td>Onychia</td>
<td>onych/o nail -ai condition</td>
<td>Inflammation of the fingernail</td>
</tr>
<tr>
<td>Paronychia</td>
<td>par- beside, near onych/o nail -ia condition</td>
<td>Infection of the skin beside the nail</td>
</tr>
<tr>
<td>Pilonidal cyst</td>
<td>pil/o hair nid/o nest -al pertaining to</td>
<td>Growth of hair in a cyst in the sacral region</td>
</tr>
<tr>
<td>Pruritus</td>
<td>prurit/o itching -us noun ending</td>
<td>Itching</td>
</tr>
<tr>
<td>Hyperhidrosis</td>
<td>hyper- excessive hidr/o sweat -osis abnormal condition</td>
<td>Excessive perspiration caused by heat, strong emotion etc</td>
</tr>
<tr>
<td>Ichthyosis</td>
<td>ichthy/o fish -osis abnormal condition</td>
<td>Category of dry skin that has the scaly appearance of a fish</td>
</tr>
</tbody>
</table>
Coding Case Scenario

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Vice President of Coding and Auditing
MiraMed Global Services

Each month we will offer a coding question for our staff to solve. If you’d like to quiz yourself, feel free. We will gladly let you know the results of your answer. The first coder from each Team (United States, Philippines and India) who correctly answers will be given a prize and recognition in the next issue of our newsletter.

**Direction:** Code for ICD-9-CM Diagnosis and its corresponding ICD-10-CM

A 49-year-old female patient suffered neck pain following a collision with another softball player. The provider's diagnosis at the time of discharge is right internal carotid artery dissection likely secondary to trauma.

**Correct Answer from Previous Case Scenario:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Condition</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
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<tbody>
<tr>
<td>Principal Diagnosis</td>
<td>Costochondritis</td>
<td>733.6</td>
<td>M94.0</td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>Hypertension</td>
<td>401.9</td>
<td>I10</td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>Smoker, current nicotine dependence on cigarettes</td>
<td>305.1</td>
<td>F17.210</td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>Overweight</td>
<td>278.02</td>
<td>E66.3</td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>Family history of ischemic heart disease</td>
<td>V17.3</td>
<td>Z82.49</td>
</tr>
</tbody>
</table>

Costochondritis is the Principal diagnosis. The principal diagnosis is defined as the condition established after study to be chiefly responsible for admission of the patient to the hospital.

Chest pain would not be coded as this is an integral symptom of costochondritis. As per coding guideline, signs and symptoms that are integral to the disease process should not be reported as additional codes.

Myocardial infarction would not be coded as it was ruled out after several diagnostic tests performed. A diagnosis described as “ruled out” is never coded. This indicates that a diagnosis originally considered as likely in no longer a possibility.
Last Month’s Winner from the Philippines:

John Erikson Vergara
Degree: B.S. in Nursing
Coding Experience: 4 years
Certification: CCS
Specialties Worked: Inpatient and Outpatient (Emergency Department, Same Day Surgery, Ancillary Services)

Last Month’s Winner from India:

A. H Fathima Suhaima
Degree: B.S. in Nutrition and Dietetics
Coding Experience: 3 years and 4 months
Certification: CPC
Specialties Worked: Radiology, Ambulance