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THE CODE

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When to Apply Modifiers

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Part 3

In part 2 of this article we discussed modifiers that may be applied when billing for multiple procedures performed on the same day (50, 51, and 59) or modifier 25, if an E&M is done in conjunction with a procedure.

Below are situations that you might encounter when procedures are repeated on the same day or during the global period and, therefore, it might be necessary to append modifier 76 or modifier 77.

Modifier 76 – Repeat procedure done by the same physician or other qualified healthcare provider.

This modifier indicates that a procedure or service was repeated in a separate session on the same day or during the global period by the same physician and indicates when it is necessary to report a repeated procedure subsequent to the original procedure. This modifier tells the payer that this is not a duplicate bill, but that the same procedure was performed twice. It, therefore, requires the use of the same procedure code. Based on the definition of modifier 76, it would be inappropriate to append modifier 76 to clinical laboratory tests on the same day. This modifier may be used on procedures or diagnostic tests.

Append

- On a procedure code that cannot be quantity billed.
- When reporting each service on a separate line, using a quantity of one and appending 76 to the subsequent procedures.
- When the same physician performs the services.
- When ordered by a physician, but performed by a technician.

Do Not Use When

- Repeat services due to equipment or other technical failure.
- For services repeated for quality control purposes.

In the operative report, the provider must indicate the medical necessity for the repeat procedure.

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If you have an article or idea to share for *The Code*, please submit to:
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"If your actions inspire others to dream more, learn more, do more and become more, you are a leader."

John Quincy Adams

When to Apply Modifiers *(continued from page 1)*

* **Medicare**

The Medicare Hospital Manual, Section 442.9, states: Use this modifier to indicate that a procedure or service was repeated in a separate operative session on the same day. Report the procedure once and then report it again with modifier 76 added (two line items on the bill).

- Medicare considers two physicians in the same group with the same specialty performing services on the same day as the same physician.
- For all procedure codes that cannot be quantity billed, always use a quantity of "1."
- **AVOID DENIALS:** bill all services performed on one day on the same claim.
- For repeat clinical diagnostic laboratory test, use modifier 91 if the service cannot be quantity billed.
- CMS does include an exception to reporting guidelines for ambulatory surgery procedures. For surgical procedures, do not use the units of service field to indicate the provider performed the procedure multiple times. Instead, report the procedure code once without a modifier, then repeat the code with modifier 76 for each additional time the provider performed the procedure.

The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, such as a complication, and requires the use of the operating room, it must be reported by adding the CPT modifier 78 to the related procedure.

Modifier 76 should not be used to report the repeat of a planned or anticipated procedure, such as debridements associated with an open fracture. Even if the exact same debridement service is done in the global period, it would be reported by appending a modifier 58 to the subsequent debridement because the service was planned or anticipated at the time of the original operation. 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 must be reported by using the CPT modifier 79.

Example: Dr. Smith orders an EKG and it is performed at 8 AM. A repeat EKG is performed at 1:00 PM. Later, the patient's condition requires a third EKG which is ordered by the same physician and done at 10 PM.
It would be billed as:

- 93000, 93000-76 and 93000-76 or
- 93000 and 93000-76 (units 2) dependent on carrier

Some payers and Medicare carriers may interpret modifier 76 differently and restrict its use to services performed on the same day, even though this is clearly not part of the CPT definition. Payers that restrict the use of modifier 76 to the same day or same 24-hour period often use the multiple procedure reduction of 50 percent for the subsequent procedure. They also state that the modifier should not be used to report a failure or inadequate outcome of the original procedure.

<u>Modifier 77 – Repeat procedure done by another Physician or other qualified health care provider.</u>
This modifier indicates that a procedure had to be repeated by a different physician in a separate encounter during the global period.

Append

- To the professional component of an X-Ray or EKG procedure when a different physician repeated the reading as the physician performing the initial interpretation believes another physician's expertise is needed.

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When to Apply Modifiers *(continued from page 2)*

- To the professional component of an X-Ray or EKG procedure when the patient has two or more tests and more than one physician provides the interpretation and report.
- When billing for multiple services on a single day and the service cannot be quantity billed.

Do Not Use When

- Billing for multiple services considered bundled.
- Billing on an Evaluation and Management Code.

Supporting medical necessity documentation must be added to the medical record describing the circumstances precipitating the repetition of the procedure or service.

Example: Patient presents with a fracture of the left femur and undergoes an ORIF by Dr. Jones. While in recovery room, the internal fixation pin is dislodged but Dr. Jones is unavailable to perform the repeat procedure. Dr. Bones a colleague from a different orthopedic group steps in and does the repeat procedure.

- Dr. Jones would bill 27236 LT (open treatment of femoral fracture, proximal end neck, internal fixation of prosthetic replacement (direct fracture exposure).
- Dr. Bones would bill 27236 LT 76.

* *The Medicare Hospital Manual, Section 442.9, guidelines are very similar to those for modifier 76. Section 442.9 states that both modifiers 76 and77 may be reported for services ordered by physicians but performed by technicians. If a technician performed the procedure (e.g., electrocardiograms [EKG]) or a therapist performed the procedure (e.g., respiratory therapy), refer to the ordering physician's notes to determine the appropriate modifier assignment. If there is a question as to who the ordering provider was and whether or not the same physician ordered the repeat procedure or service, code based on whether or not the physician reporting the service is the same. If the same physician ordered the repeat services, use modifier 76. If a different physician ordered the repeat service or procedure, append modifier 77.*

(To be continued in the next issue.)

"Success is a little like wrestling a gorilla. You don't quit when you are tired—you quit when the gorilla is tired."

Robert Strauss

V-Codes

By: Hemavathy S
Manager, Operations, Ajuba International, LLC

ICD9-CM provides V codes to deal with encounters for circumstances other than a disease or injury. V codes are used to identify when a person who is not currently sick encounters the health services for some specific purpose such as vaccination. V codes are also used when a person with a known disease or injury, whether it is current or resolving, encounters the health care system for a specific treatment of that disease or injury such as a cast change. Lastly, v codes can also be used when some circumstance or problem is present which influences the person's health status, but is not in itself a current illness or injury such as a personal history of cancer. Appropriate V code assignment is extremely important in terms of reporting, medical necessity and avoiding inaccurate denials.

V-codes are important because they add to the patient's story, and allow the codes to let other healthcare workers and payers know the complexity and severity of the patient's visit and what levels of care had to be provided to each unique patient. With the advent of Electronic Health Records (EHRs), healthcare is going global and communication and knowledge sharing are key components of the drive to get there.

V-codes are used in both the inpatient and outpatient care setting, and in the past were typically more germane to outpatient encounters. V-codes can be used as either a first-listed or principle diagnosis code to describe or represent the encounter, or as additional codes to provide more specificity to each patient's distinctive encounter. With the introduction of All Patient Refined Diagnosis Related Groups (APR-DRGs) and their acceptance and use by many states and individual hospitals, V-codes have come into their own. There are some V-codes that are comorbidies (CCs), but there are a large number of them that impact risk-adjusted methodologies used by the Centers for Medicare and Medicaid Services (CMS) and many of the organizations that now publish comparisons of quality of care for hospitals as well as providers.

V-codes are located in the index in the same manner that other chapter codes are found. Main terms can sometimes be a little tricky because terms used by physicians are not always the same as the main terms used by the code book. It is very important you become familiar with all types of V-codes. Here is a list of the main terms to reference V-codes:

- Adjustment
- Administration, prophylactic
- Admission
- Aftercare
- Attention to
- Chemotherapy
- Dialysis
- Donor
- Encounter
- Examination
- Fitting
- Follow-up
- Immunotherapy
- Radiotherapy
- Therapy

The V-code guidelines are listed in Section I.C.18; Classification of Factors influencing Health Services and Contact with Health Service (Supplemental V01-V89).

The official coding guidelines state that there are four primary circumstances for the uses of V-codes.

1. A person who is not currently sick encounters the health system for some specific reason, such as to act as an organ donor, to receive prophylactic care, inoculations or health screenings, or to receive counseling on health-related issues. The most important part of this statement is that some V-codes are only used on patients that are accessing a healthcare provider for reasons other than the treatment of a current illness.

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V-Codes *(continued from page 4)*

- V03.82: Need for prophylactic vaccination
- V06.4: Need for prophylactic vaccination and inoculation for Measles-Mumps-Rubella [MMR]
- V61.21: Counseling for victim of child abuse
- V65.46: Encounter for insulin pump training
- V59.02: Donor; stem cell

2. A person with a resolving disease or injury, or a chronic, long-term condition requiring continuous care encounters the healthcare system for specific aftercare of that disease or injury (e.g., dialysis for renal disease, chemotherapy for malignancy, cast change). A diagnosis/symptom code should be used whenever a current acute diagnosis is being treated or a sign or symptom is being studied. These types of V-codes are self-explanatory and are among the V-codes that must be reported in order to support mandatory coding guidelines.
   - V54.10: Aftercare for healing traumatic fracture of arm
   - V55.3: Attention to colostomy
   - V58.0: Radiotherapy
   - V58.42: Aftercare following surgery for neoplasm

3. Circumstances or problems influence a person's health status but are not a current illness or injury. These codes are not mandatory but some of them are very important for reporting risk-adjustment and mortality scores. The impact expands the use of goods and services by physicians and facilities.
   - V13.22: Personal history of cervical dysplasia
   - V15.82: History of tobacco use
   - V23.0: Pregnancy with a history of infertility

4. Newborns, to indicate birth status:
   - V30: Single liveborn
   - V31: Twin mate liveborn

Terms used in the medical record can often give the coder a clue as to what type of code should be assigned:

1. Contact with: Exposure to communicable disease without current symptoms, as well as exposure to dangerous substances such as asbestos, lead and body fluids of a diseased individual. These issues often require different care and treatment modalities and impact utilization of goods and services.
   - V01.79: Other viral diseases
   - V15.85: Contact with potentially hazardous body fluids
   - V15.86: Contact with lead

2. History of: Personal to the patient and is a condition that no longer exists and not receiving any treatment, but has the potential for re-occurrence. The exceptions to this rule are allergic reactions, both to medicinal agents [V14] and allergy, other than to medicinal agents [V15.0]. Once the patient has had an allergic reaction they are always considered allergic to the substance and this code should be used whenever possible for each encounter as it impacts the medical decision process of the physician and can be responsible for extra or different care and treatment modalities. These codes are used to support changes in treatment modalities. They do this by completing the full clinical picture of the patient by their past medical issues and their impact of treatment choices.

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V-Codes *(continued from page 5)*

- V11.3: History of alcoholism
- V12.53: History of sudden cardiac death, successfully resuscitated
- V10: Personal history of malignant neoplasm
- V13.6: Personal history of congenital (corrected) malformations
- V12.41: Personal history of a benign neoplasm of the brain
- V14: Personal history of an allergy to medicinal agents
- V42.0: Personal history of a kidney transplant [v42.0]

3. Family history of: When the patient has a family member who has had a disease that is known to run in families and could place the patient in a high risk category, such as breast cancer in the mother of the patient. These codes can support medical decision making by the physician depending on the diagnostic tests that are ordered.
   - V16.3: Family history of malignant neoplasm of the breast
   - V19.6: Family history of other conditions, allergic disorders

4. Follow-up: Use for continuing clinical surveillance following completed treatment of a disease or treatment of injury. These codes better describe the level of care being delivered to the patient. Using acute care codes for situations that have been treated once when the patient is here for follow-up, is the incorrect way to report these types of encounters. This situation has been addressed in ICD-10 by a new requirement called the 7th character extension. This rule allows coders to use the acute diagnosis as the reason for the visit with a 7th character extension that states the level of care; initial, subsequent, or sequelae.
   - V67.0: Follow-up examination, following surgery, unspecified
   - V24.0: Postpartum care and evaluation
   - V67.1/V67.2: Follow-up examination following chemotherapy /radiotherapy

5. Aftercare: These codes should be used to explain the situation when the initial treatment of a disease is over and the patient still needs continued care during healing or recovery. These codes should not be used for treatment of a current disease, with the exception of chemotherapy, radiotherapy and immunotherapy for neoplastic conditions. These follow-up codes are always first-listed or the principle diagnosis, followed by the neoplasm code. These codes can be used as first-listed or secondary codes. They are usually used as the first-listed or principle to describe the reason for the encounter but can also be used as the secondary code to describe any aftercare given in addition to the reason for the encounter.
   - V51.0: Encounter for breast reconstruction following mastectomy
   - V54.13: Aftercare for healing traumatic fracture of the hip
   - V55.0: Attention to artificial opening; tracheostomy
   - V58.11: Encounter for antineoplastic chemotherapy

6. Screening: Testing for disease precursors in seemingly well individuals. If a condition is discovered during a screening exam, then the code for the condition may be assigned as an additional diagnosis. Do not use a screening code when the screening is part of a routine physical, such as a pap smear. These codes should have a personal or family V-code assigned along with the screening code.
   - V76.51: Special screening for malignant neoplasms, colon
   - V76.11: Special screening for malignant neoplasms, mammogram for high-risk patient
   - V82.81 Screening for osteoporosis

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V-Codes *(continued from page 6)*

7. Status: An indication that the patient has some residual or sequelae of a disease or condition, or a condition that will require special care. Special care is reflected in APR-DRG grouping because the effect of a patient's status can significantly increase the use of resources. The status code is different from a history code because a history code states the patient no longer has the condition. Status codes play a big role in the patient's severity of illness and risk of mortality.

Inpatient vs. Outpatient Coding

Certain V-codes may be used as the principal or first-listed diagnosis, but coders should review the ICD-9-CM official coding guidelines for specific sequencing instructions. Please note that sequencing guidelines or edits for V-codes are different for inpatient and outpatient reporting. Official coding guidelines for reporting V-codes have been incorporated into the ICD-9-CM Official Guidelines for Coding and Reporting. The V-code section includes a list of conditions that may only be sequenced as first-listed diagnoses. The guidelines indicate general code sequencing rules for outpatient cases, which include physician office and clinic encounters. Effective October 1, 2009, the V-code table, which provided sequencing instructions related to "secondary only" V-codes, was deleted by the National Center for Healthcare Statistics. Coders should refer to each section of V-codes in the guidelines themselves for sequencing guidance.

For inpatient encounters, coders should ensure that they are following the Medicare Code Edit (MCE) rules, particularly for Medicare cases. Medicare Code Edit (MCE) #9, Unacceptable Principal Diagnosis, contains codes for conditions that normally would not require an inpatient level of care. In some cases, V-codes are acceptable as principal diagnosis if followed by a secondary condition explaining the diagnostic reason for the encounter. The codes in category V57, Care involving the use of rehabilitation procedures, illustrate this situation. Coders should ascertain whether edits that appear in ICD-9-CM code books or software are related to inpatient or outpatient guidelines.

Did You Know?

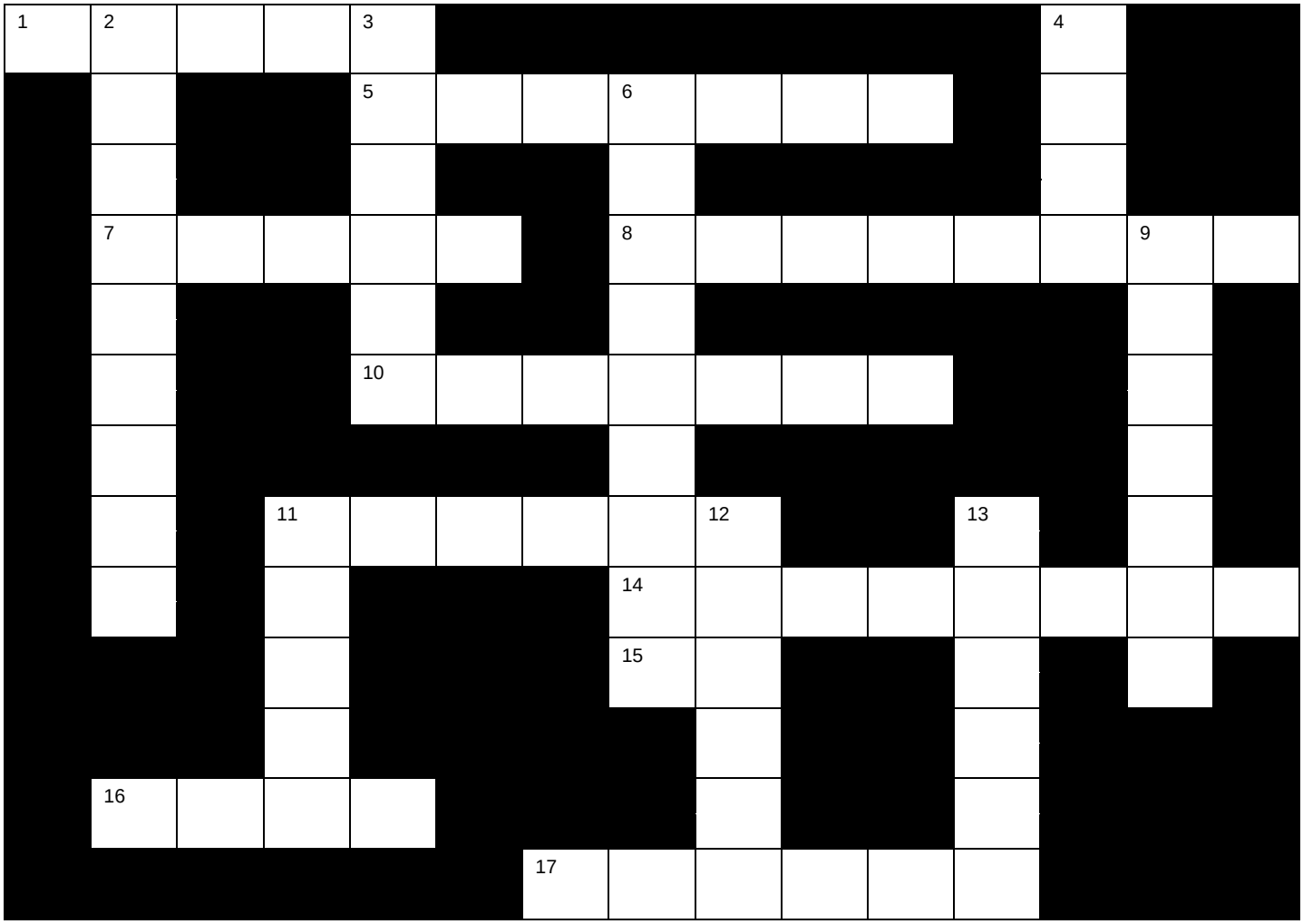
By: Evan Lendle Ramos, RN, CCS
Senior Manager, Training Department, MiraMed Philippines Group, LLC—Philippines Branch

- 11% of people are left handed.
- Unless food is mixed with saliva you can't taste it.
- The average person falls asleep in 7 minutes.
- 8% of people have an extra rib.
- The smallest bones in the human body are found in your ear.
- You burn more calories eating celery than it contains (the more you eat, the thinner you become).
- All the blinking in one day equates to having your eyes closed for 30 minutes.
- Your foot has 26 bones in it.
- The average human brain contains around 78% water.
- Your brain uses between 20% - 25% of the oxygen you breathe.
- 25% of your bones are in your feet.
- Your tongue is the fastest healing part of your body.
- A 1 minute kiss burns 26 calories.
- You burn more calories sleeping than watching TV.
- An average person will spend 25 years asleep.
- The most common mental illnesses are anxiety and depression.
- Your skin is the largest organ making up the human body.
- Enamel is the hardest substance in your body.
- The hyoid bone in your throat is the only bone in your body not attached to any other.

Ref: http://www.did-you-knows.com/did-you-know-facts/human-body.php

Crossword Puzzle

By: Kim K. Capello,
Administrative Assistant to Sharon Hughes, MiraMed Global Services



ACROSS

1 Used to describe encounters with circumstances other than disease or injury.
5 Describes an illness or medical condition that lasts over a long period of time.
7 A bubbly or crackling sound in lungs.
8 A small tube inserted into the bladder to remove urine.
10 A person who has lost all or part of a limb.
11 Sheet of fibrous connective tissue separating and supporting muscle.
14 A substance causing damage to the inner ear or auditory nerve.
15 The opposite of yes.
16 A closed sac or capsule usually filled with fluid.
17 Open, crater-like lesions on the skin or mucous membranes.

DOWN

2 A disease of the liver.
3 An itchy, inflammatory condition of the skin.
4 Cells located in the tissues that release chemicals in response to injury or foreign material.
6 An obstruction or blockage.
9 A disease that is always present in a specific region.
11 A human child in utero between 8 weeks and birth.
12 A predisposition toward hypersensitivities.
13 Poisonous substances that can harm or interfere with the body.

Coding Case Scenario

By: Fred Wulf, CCS, CCDS, DABCM
Manager, Coding and Auditing Services, MiraMed Global Services

Each month 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 (Philippines and India) who correctly answers will be given a prize and recognition in the next issue of our newsletter. Send your answers to evan.ramos@miramedgs.com and denise.nash@miramedgs.com.

- CC: I want to quit drinking
- HPI: Patient is a 56 YOWM with two hours of intermittent hand tremors associated with increasing anxiety. He drinks about one liter of vodka per day. His last drink was six hours ago.
- PMH: Remarkable ETOH withdrawal seizures in the past (most recently in January 2014).
- SH: Remarkable for long term ETOH abuse with many attempts at sobriety.
- FH: Remarkable for alcoholism in several first degree relatives.
- ROS: CV - No palpitations or orthopnea; GI - No N/V/D/hematemesis; Respiratory - No cough or hemoptysis; and all other systems reviewed are negative.
- BP: 166/96, HR 105, RR 22
- EYES: Anicteric sclerae.
- RESPIRATORY: Lungs are clear to auscultation bilaterally (CTA).
- CARDIOVASCULAR: RRR.
- GI: Normoactive Bowel Sounds (NABS).
- SKIN: No jaundice. Warm and dry.
- NEURO: Fine, resting tremors in both hands.
- PSYCH: A&OX3
- LABS: Na 136, K 4.9, HCO3 24, Cl 101, BUN 24, creatinine 0.8, HGB 12, HCT 36
- EKG: Reviewed and shows sinus tachycardia. No ST changes.
- CXR report: No active disease (NAD).
- Impression: Acute alcohol withdrawal in patient with history of withdrawal seizures in the past.
- Plan: Admit to the hospitalist service; 5 mg IV valium now; Clinical Institute Withdrawal Assessment (CIWA) protocol supplemented by scheduled IV Ativan for 24 hours; Banana bag (IV fluid with multi-vitamins); and Social Work (SW) consult in a.m. to assist with rehab options.

Correct Answer from Previous Case Scenario:

- For Principal Diagnosis: In the Alphabetic index, the main term is Diabetes, diabetic--> Retinopathy 250.5 [362.01]. Fifth digit 1 will be assigned to 250.5 since the patient has Type 1 DM, not stated as uncontrolled.
- For Secondary Diagnosis: 362.01 is the appropriate code for retinal microaneurysmal diabetic retinopathy and as instructed by the coding convention for slanted bracket.
- As per Official ICD-9-CM Guidelines for Coding and Reporting I.C.3.4: "Assigning and sequencing diabetes codes and associated conditions."
- When assigning codes for diabetes and its associated conditions, the code(s) from category 250 must be sequenced before the codes for the associated conditions.
- For CPT Procedure: In the index, main term Vitrectomy Photocoagulation 67040. Modifier 50 is appended to indicate bilateral procedure.

CONGRATULATIONS!

Last Month's Winner from India:

Blessing Sivaraj

Degrees: M.Sc., Biotechnology
MBA, Hospital Management

From January of 2014, Blessing has been working with Ajuba on the KSB and Our Lady of Lourdes (OLOL) coding projects and was one of the pioneering coders on the OLOL Project.

Last Month's Winner from Philippines:

Rean Manzano

Degree: B.S., Nursing

Rean Joined MiraMed Philippines on October 14, 2013. He is currently working on the Montefiore Emergency Room Project.