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THE CODE

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When to Apply Modifiers

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Part 4

In part 3 of this article we discussed modifiers that may be applied 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.

Below are situations that you might encounter when billing for split or shared work of a surgical procedure between providers and therefore it might be necessary to append modifier 62 (two different specialty co-surgeons) or modifier 66 (surgical team).

Modifier 62 – Two surgeons (each in a different specialty) performing a specific procedure.

There are two categories of surgical procedures for which co-surgery may be covered. Codes not listed as Category I or Category II are not eligible for reimbursement for co-surgery.

- Category I procedure codes can be paid for co-surgery when an operative report supporting the need for co-surgeons (of the same or different specialties) is submitted with the claim.
  - Surgical procedure requires two or more surgeons who usually have different types of skill and expertise to perform a single procedure, which has two separate but integrated parts, performed during the same operative session under the same anesthesia.
  - Example: Procedure 61575 (Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion).

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If you have an article or idea to share for *The Code*, please submit to:
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By failing to prepare, you are preparing to fail.

Benjamin Franklin

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

  - Example: Code 61548 (hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, non-stereotactic) frequently requires a neurosurgeon and otolaryngologist.
  - Example: Procedure 62223 (Creation of shunt; ventriculoperitoneal, -pleural, other terminus) frequently requires the skills of a neurosurgeon and general surgeon. Both surgeons would bill the same procedure code.

- Category II procedure codes do not require documentation of the medical necessity for co-surgery unless the co-surgery is performed by surgeons of the same specialty. If co-surgeons are of the same specialty, operative reports must be submitted.
  - Example: Procedure 63015 Laminectomy with explorations and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (e.g., spinal stenosis). More than 2 vertebral segments; cervical; billed with 22842 Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments, and 22600 Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment may require the skills of a neurosurgeon and an orthopedic surgeon. Each surgeon would bill the procedure code he or she performed.
  - Example: An urologist performs procedure 51845 Abdomino-vaginal vesical neck suspension, with or without endoscopic control (e.g., Stamey, RAZ, Modified Pereyra) and a gynecologist performs a hysterectomy (58150-Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)). Note that this applies to a urologist and gynecologist.

Append

- When the skill of two surgeons' (usually of different skills) *different specialties* may be required in the management of a specific surgical procedure.
- When each surgeon performs a separate portion of one procedure (identified by a single CPT).
- When each surgeon would bill the same CPT code with modifier 62.

Do Not Use When

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 the Modifier 80 or Modifier 82 added, as appropriate.

Example:

- Two surgeons perform an upper gastrointestinal endoscopy with directed placement of a percutaneous gastrostomy tube. One surgeon performs the endoscopy. The other surgeon makes an incision into the abdomen and inserts the gastrostomy tube.
- Each would bill 43246-62

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

When two physicians perform the placement of the PEG, both bill code 43246 with the 62 Modifier. Both physicians must dictate their own procedure report.

When billing for co-surgery, it is important to communicate with the other surgeon's office to be certain that the claims are submitted properly. Global surgery rules apply to each of the physicians participating in a co-surgery. Documentation of the medical necessity for two surgeons is required for certain services identified in the Medicare Physician Fee Schedule Database (MPFSDB). Reimbursement for co-surgeons is 62.5% of the global surgical fee schedule.

Modifier 66 – Team of surgeons (more than two surgeons of different specialties) performing a specific procedure.

Append

- More than two surgeons
- Used for highly-complex or intricate procedures which require multiple concomitantly operating physicians
- Usually of different specialties
- May require assistance of specially trained ancillary personnel or specialized equipment

Examples:

- Transplants
- Separation of conjoined twins

Global surgery rules apply to each of the surgeons participating in a team surgery. The MPFSDB identifies certain services with modifier 66 which must be sufficiently documented to establish that a team was medically necessary. All claims for the team surgeons must contain sufficient information to allow pricing "by report" (operative note).

Example:

- A 44YO female dyspneic at rest from severe COPD requiring home O2 was seen and the MD decided that a transplant was necessary. After being placed on bypass the patient underwent a thoracotomy. Dr. Smith removed the left lung by dividing the left mainstem bronchus at the level of the LUL. Dr. Jones divided the two pulmonary veins and single pulmonary artery distally. An allograft left lung was inserted. The recipient left mainstem bronchus and pulmonary artery are re-resected to accommodate the transplant. The recipient pulmonary veins are opened into the left atrium. An end-to-end anastomosis of the recipient's respective structures (pulmonary artery, mainstem bronchus and left atrial cuffs) was made to the similar donor structures. Two chest tubes were inserted. Bronchoscopy was performed in the operating room.
- **32852-66** lung transplant, single; with cardiopulmonary bypass would be reported for each of the physicians

Please refer to the CMS Physician Fee Schedule for code payment policy indicators which can be found at http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

To be continued in the next issue.

Improve Reimbursement with Modifiers

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Modifier Number	Modifier Name	Description	Tips on Using this Modifier
-22	Unusual Procedural Service	Used when the service provided is greater than that usually required for the listed procedure.	In order to receive extra reimbursement, the operation report must document the extra work provided, and usually must be sent with the claim.
-24	Unrelated E&M by the Same Physician During the Post-Op Period	E&M service performed during the post-op period is unrelated to the original procedure.	Documentation and diagnosis codes must support that this service was performed during the post-op period for a reason unrelated to the original procedure.
-25	Significant, Separately Identifiable E&M by the Same Physician on the Same Day as a Procedure or Other Service	On the day that a procedure is performed, the patient's condition warranted a separate E&M beyond the usual pre-op and post-op care associated with the procedure.	Example: Patient reported to the office for a scheduled Cystoscopy. Upon arrival, patient had new complaints of groin pain, nausea and fever. Physician examined the patient, prescribed medication and made the decision to proceed with the Cystoscopy.
-26	Professional Component	Certain procedures have both a professional and a technical component.	When the physician component is reported separately, the service is identified by adding modifier –26 to the CPT code (i.e. reading and reporting on an EKG or EEG). The physician's interpretation must be documented.
-52	Reduced Services	When a service or procedure is partially reduced or eliminated at the physician's discretion.	Example: If an enterocystoplasty (51960) is performed and the surgeon elects not to perform intestinal anastomosis, a –52 modifier would be attached to the procedure code.
-53	Discontinued Procedure	When the surgeon elects to terminate a surgical or diagnostic procedure, this modifier indicates that a procedure was started but discontinued.	Do not use this modifier to report elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical prep. This modifier is most frequently used when a procedure is reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient.
-57	Decision for Surgery	Used to indicate that an E&M service resulted in the initial decision to perform the surgery.	Example: Physician consults in the ED, after which a decision is made that the patient needs surgery immediately. The modifier would be placed on the consult code, and the surgery would also be billed on the same day or next day.

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Modifier Number	Modifier Name	Description	Tips on Using this Modifier
-58	Staged or Related Procedure by Same Physician During the Post-Op Period	Physician must document that the performance of a procedure or service during the post-op period was: (a) planned prospectively, (b) more extensive than original procedure; or (c) for therapy following a diagnostic surgical procedure.	This modifier is not to be used to report the treatment of a problem that requires a return to the operating room. See modifier –78.
-59	Distinct Procedure Service	Indicates that a service was distinct or independent from other services performed on the same day.	Example: Physician performs an emergency stricture dilation in the morning, and performs a more extensive surgery in the afternoon. Modifier –59 would show that these were two distinct procedures. Otherwise, the dilation would be bundled into the more extensive surgery.
-77	Repeat Procedure by Another Physician	Used when the physician needs to indicate that a procedure or service performed by another physician had to be repeated.	Example: A physician repeats a nephrolithotomy on a patient previously operated on at another health system.
-78	Return to the OR for a Related Procedure During the Post-Op Period	This modifier indicates a procedure was performed during the post-op period of the initial procedure.	Example: Patient who undergoes cystoscopy with removal of bladder tumor now undergoes an additional cystoscopy with insertion of a radioactive substance.
-79	Unrelated Procedure by the Same Physician During the Post-Op Period	Indicates the post-op period was unrelated to the original procedure.	Patient is 60 days status post drainage of a renal abscess undergoes a cystoscopy with biopsy. Modifier -79 would be appended to the second procedure.

Set your sights high, the higher the better. Expect the most wonderful things to happen, not in the future but right now. Realize that nothing is too good. Allow absolutely nothing to hamper you or hold you up in any way.

Eileen Caddy

Supporting U.S. Headquartered Healthcare Offshore BPO Companies Makes Good Business Sense

Phil Solomon
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U.S. based healthcare Business Process Outsourcing (BPO) companies in the Philippines and other countries are contributing to economic growth and prosperity around the globe. The financial benefit offshore BPO companies create extends beyond the host country. U.S. based employees benefit because there is a need to manage the services delivered through offshore locations in the U.S. The American worker is not the only one who benefits from a growing global strategy. U.S. Healthcare providers who use cost-effective offshore strategies benefit in several ways:

- Delivery of services, such as medical coding can keep up with healthcare's growing demand, even though there aren't enough qualified U.S. employees to fill those highly skilled jobs.
- Providers benefit by reducing operating costs so existing services can be delivered at the same level without resorting to employee layoffs.
- U.S. citizens benefit by receiving better care because providers can leverage operating costs savings and invest in advanced technologies and the best and brightest care providers.

Not everyone is in favor of outsourcing work overseas; however, the atmosphere is changing. Offshore BPO outsourcing soon will becoming less of a lightning rod than it has been reported by Manufacturing and Technology News. U.S. federal agencies involved in economic data are on the verge of a major and transformative change in the way they classify companies that have outsourced their U.S. production to foreign manufacturing and service contractors.

The change could radically increase U.S. production statistics by classifying "factory-less goods producers" as domestic manufacturers. Companies like Apple will no longer be considered "wholesale traders," and their sales would be counted as U.S. production, even though none of their manufacturing is in the United States.

The changes now being finalized by the U.S. government would be implemented in the 2017 North America Industry Classification System when factory-less goods and services producers will be classified as U.S. producers. The new classification system of manufacturers would introduce "significant discontinuity" to a wide range of statistics gathered by the government, say those involved. This same change in classification will affect those American companies who own and run offshore service centers.

The practice of outsourcing is as old as business itself. A 19th-century manufacturing company might have had its own machines but not its own fleet of horse-drawn drays to distribute its wares. Today, many U.S. citizens, American companies and State-run organizations still assail work performed by offshore manufacturers and service delivery companies. That sentiment hasn't slowed the growth, acceptance and economic boon offshore outsourcing has experienced.

Those who question the strategy of global outsourcing should consider how their lives would be different without it. It is commonplace to buy goods and receive services from around the globe. For example, consumers don't give it a second thought when they purchase a Canon Camera that is made in China, a Blackberry Cellphone that is made in Canada, Clinique Makeup made in Belgium and even produce imported from Chile. How many people would own iPhone's today if they cost $2,500? If they were manufactured exclusively in the U.S., they likely would cost that much or more.

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Supporting U.S. Headquartered Healthcare Offshore BPO Companies Makes Good Business Sense *(continued from page 6)*

The State of New Jersey has taken a different approach to addressing the growing trend of offshore outsourcing of services. Due to its 2005 State law that prohibits foreign outsourcing of State services contracts, New Jersey residents won't experience any of the benefits offshore service providers can offer. New Jersey's decision to outlaw outsourcing of State services has created quite the conundrum. When President Obama attends a State-run event wearing one of his expensive Ermenegildo Zegna suits, made from fabrics in Italy and constructed in Switzerland, is he acting un-American by attending a State run event wearing goods that were made offshore?

Is it un-American to support U.S. based companies who deliver services from offshore locations? Should State-run or non-profit healthcare providers shun offshore BPO outsourcers? It isn't an easy decision to make for some providers. When deciding to offshore or not offshore BPO work, decision makers should consider how the global economy has changed their own consumption habits and their quality of life.

Many of the products and services purchased from the neighborhood Home Depot, Wal-Mart, Target or grocery store comes from across the globe. It's becoming more difficult to find products and services exclusively made or delivered in the U.S.A. Many manufacturers such as BMW are leveraging a blended-shore approach by manufacturing their parts in Germany and assembling their cars in South Carolina. Many industries have embraced a blended shore global business strategy. Perhaps it's time for healthcare providers to consider expanding the use of offshore outsourcers.

Non-Physician Practitioners Medicare Rules

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Vice President of Regulatory Affairs & Research
MiraMed Global Services

Jackson Healthcare recently compiled some statistics about how today's practices use non-physician practitioners (NPPs). Out of 1,527 physician respondents:

- Thirty-five percent use Nurse Practitioners (NPs), 30 percent use Physician Assistants (PAs) and 10 percent use Clinical Nurse Specialist (CNS) or certified registered nurse anesthetists (CRNA).
- Thirty percent increased their use of NPPs over the past year, while 4 percent use NPPs less.
- PAs gained ground on NPs as the favored NPP, with PA use up 5 percentage points since 2013.
- NPs are more popular among pediatricians and office-based specialties, while PAs are used more often in hospital-based specialties such as critical care, emergency medicine and hospitalist practice.
- Most (76 percent) said using NPPs allows the practice to treat more patients each day. Both NPs and PAs reported seeing 16 to 18 patients per day.
- However, 47 percent foresaw risks with expanding NPs' responsibility for patient care, as did 32 percent regarding PAs.[1]

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[1] http://www.jacksonhealthcare.com/media/182734/advancedpracticetrendsreport_ebook0313_lr.pdf

Non-Physician Practitioners Medicare Rules *(continued from page 7)*

Recognizing that the growth in using NPPs also brings some additional risks a review of the Medicare reimbursement rules seems timely. NPPs have three different billing options under the Medicare program. The services may be direct billed, billed as incident to or billed as a shared/split service. How the NPP and the physician interact with a patient on the same day determines how the service should be billed and how it is reimbursed.

Direct billing may occur in the hospital or office setting and is when the service is rendered and billed by the rendering NPP. The NPPs NPI is used to report the service and Medicare reimburses the service at 85 percent of the Medicare Physician Fee Schedule (MPFS). When an NPP is direct billing they may see any type of patient, new or established, new problems, and work independently within their Scope of Practice.

Incident to billing applies only to the office setting when the NPP sees an established patient with a set plan of care previously developed by the physician. Even when it is an established patient, the NPP cannot see the patient if they have a new problem and bill it incident to, since the physician has not yet developed the treatment plan. Another important rule for incident to billing is a supervising (billing) physician must be present in the office suite when the NPP is seeing established patients for established problems. If the visit meets the Medicare guidelines, the NPPs visit is billed as if the physician saw the patient, using the physician's NPI number and the service is reimbursed at 100 percent of MPFS amount.

A shared/split billing is when both the physician and a NPP have a face-to-face encounter with the patient on the same day in the hospital setting, and the services of each are documented and signed. The combined work of the NPP and the physician is billed under the appropriate hospital E & M code and the service is billed to Medicare under the physician's NPI number again at the higher physician rate. If only the NPP sees the patient in the hospital that day the service is billed under the NPP's NPI number and is reimbursed at 85 percent of the MPFS rate.

Sounds pretty straightforward right? Well let's review some NPP scenarios:

1. Is a change in medication made by a PA seeing a patient in follow-up with an established diagnosis when the physician is present in the office billable under the incident to provisions? Yes, the PA is treating an established problem with a prior treatment plan.
2. An NPP sees a patient for an established diagnosis but makes a new diagnosis and starts a new treatment. The physician is in the office. The physician did not see the patient but discussed and reviewed the NPP's note. Is this reported under the physician or NPP? This scenario can only be reported under the NPP.
3. If the service performed in the office meets the shared/split billing guidelines but does not meet the 'incident to' requirements in the office, can it still bill under the MD/DO? No. Shared/split visits in the office must meet the 'incident to' requirements. The NPP must bill for the services under his/her own Medicare number.
4. Are nurses (RN & LPN) able to perform services 'incident to' an NPP when the NPP is present in the office? The 'incident to' requirements apply to services 'incident to' both the physician and the NPP. A nurse is able to provide a service 'incident to' the NPP when the situation meets all requirements. If the nurse or auxiliary person performs E/M services, use code 99211.

WORD SEARCH

D	U	S	I	S	Y	L	A	I	D	U	I	H	J	A
J	R	V	C	O	D	E	I	M	R	D	E	M	N	M
M	K	G	B	K	P	H	J	I	A	N	Z	E	W	O
I	L	C	C	F	E	M	O	R	A	L	S	A	P	B
T	Z	O	I	P	J	D	S	A	G	T	H	S	O	S
O	N	D	G	M	L	Q	I	M	H	G	T	L	S	H
S	B	I	P	R	Q	R	K	E	A	A	R	E	O	N
I	E	N	F	Y	X	C	S	D	M	S	R	S	L	E
S	N	G	L	I	P	I	D	S	N	T	E	C	D	A
M	I	G	V	R	A	W	V	C	H	R	O	N	I	C
X	G	T	C	E	B	R	D	N	T	I	L	Z	A	N
Z	N	R	L	M	M	B	A	R	U	C	B	R	B	S
M	P	W	Q	B	L	A	N	E	R	D	A	C	E	R
U	H	V	T	R	N	M	W	N	C	D	S	Y	T	K
S	M	N	O	Y	Y	E	R	A	C	X	I	D	E	F
C	Q	B	L	O	O	D	G	L	H	I	L	J	S	K
L	W	S	Z	B	K	L	M	P	O	N	A	Q	R	S
E	S	I	S	O	R	B	I	F	A	B	R	D	E	Z

VCODE
MIRAMED
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DIALYSIS
EMBRYO
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MEASLES
LIPIDS
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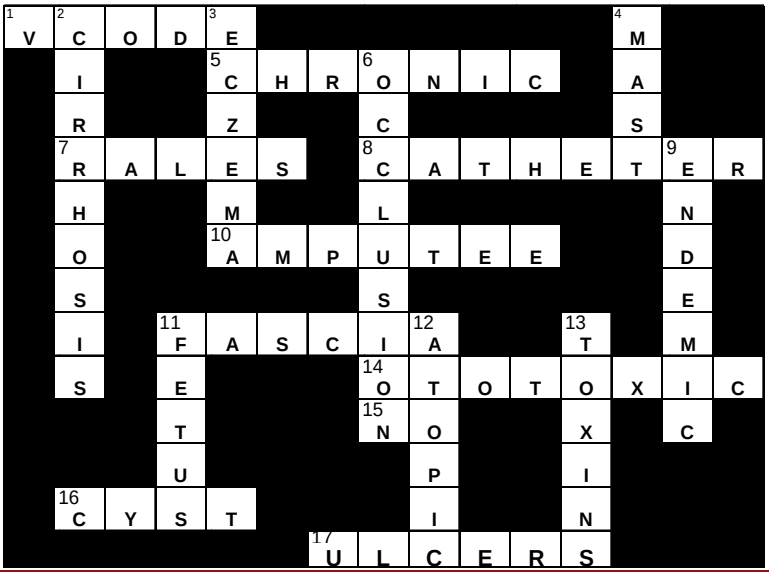
RENAL

ANSWERS TO PREVIOUS PUZZLE



Coding Case Scenario

By Denise M. Nash, MD, CCS, CIM
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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. Read the case scenario below and code for appropriate ICD-10 codes. Send your answers to evan.ramos@miramedgs.com and denise.nash@miramedgs.com.

CODING CASE SCENARIO:

An 86-year-old male patient presents with complaints of right lateral ulcer of the foot. An Iodosorb dressing was applied and surgical consult was ordered.

EXAM:
Skin: Pressure ulcer right heel, 9 x 10 cm that invades the muscle and fascia. Edema of both lower extremities and feet
Cardiovascular: Peripheral vascular disease
Musculoskeletal: Difficulty walking. Pain in lower extremities and feet

ASSESSMENT:
Pressure ulcer, right foot
Peripheral vascular disease

Correct Answer from Previous Case Scenario:

E/M level is 99223.

History is comprehensive. Physical exam is comprehensive. MDM is high complexity.

- History is comprehensive because of the following:
  - HPI Elements: Location for hand, duration for two hours, timing for intermittent and associated signs and symptoms for associated increasing anxiety. HPI is extended for having 4 elements identified.
  - ROS: Cardiovascular for no palpitation, respiratory for no orthopnea, no cough, gastrointestinal for no nausea and vomiting, hematemesis; also a statement of all other systems reviewed are negative will warrant for complete ROS.
  - PFSH: Past history for remarkable ETOH withdrawal seizures in the past (most recently in January 2014); family history for remarkable for alcoholism in several first degree relatives, social history for remarkable for long-term ETOH abuse with many attempts at sobriety. Three elements of history are identified, thus it is a complete PFSH.
- Physical exam is comprehensive because eight organ systems are identified:
  - Constitutional: BP: 166/96, HR 105, RR 22
  - Eyes: Anicteric sclerae
  - Cardiovascular: RRR
  - Respiratory: Lungs are clear to auscultation bilaterally (CTA)
  - GastroIntestinal: Normoactive Bowel Sounds (NABS)
  - Skin: No jaundice. Warm and dry
  - Neuro: Fine resting tremors in both hands
  - Psych: A&OX3

- Medical Decision Making is High complexity because of the following:
  - Number of diagnoses or treatment options: new problem with additional work-up planned warrants for extensive.
  - Amount and/or complexity of data reviewed: 1 point for labs, 1 point for EKG, and 1 point for CXR. This is 3 points and would classify as multiple.
  - Risk: it has a parenteral controlled substances – 5 mg of IV valium, scheduled IV Ativan for 24 hours.

Diagnoses:

- 291.81 for Acute alcohol withdrawal
- 300.00 for anxiety
- 781.0 for tremors
- 427.89 for sinus tachycardia

CONGRATULATIONS!

Last Month's Winner from India:

Gopalakrishnan Pandurangan, CPC

Degree: Bachelor of Physiotherapy
Coding Experience: 6 Years
Certification: CPC
Designation: Senior Officer – Medical Coding
Specialties Worked: Ambulatory Surgery Coding and Emergency Department.

Last Month's Winner from Philippines:

Marlie Baliuag

Degree: B.S. in Nursing
Coding Experience: 10 Months
Certification: CCA
Designation: ABC Surgery – Auditor
Specialties Worked: Surgery Coding, Evaluation Management, Emergency Room Visits, Observation, Hospital Care and Consultations.