national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Medicare Part B 2024

Spring/Summer Virtual Conference

Mastering Medicare: Tuesday Tutorials

Evaluation and Management Modifiers: When to Use Modifiers 24, 25 or 57

6/4/2024

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

NGSMU
NGS Medicare University
Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Objective

Provide clarification on the proper usage of evaluation and management modifiers to ensure proper coding.

Agenda

- Modifier Overview
- Fee Schedule
- Fee Schedule Assistance
- Evaluation and Management Modifiers
- National Correct Coding Initiative Procedure-to-Procedure Coding
- Redetermination
- Reopening

Modifier Overview

Modifiers

- Two digits (alpha or numeric)
- Gives new or different meaning to code (modifies a procedure)
  - Affect reimbursement in most cases
- Some codes require modifiers
- Not all modifiers are recognized by Medicare

Modifiers

- Two types of modifiers
  - Level I – Numeric
    - American Medical Association/CPT codes
  - Level II – Alpha
    - HCPCS/National

Reimbursement Versus Informational

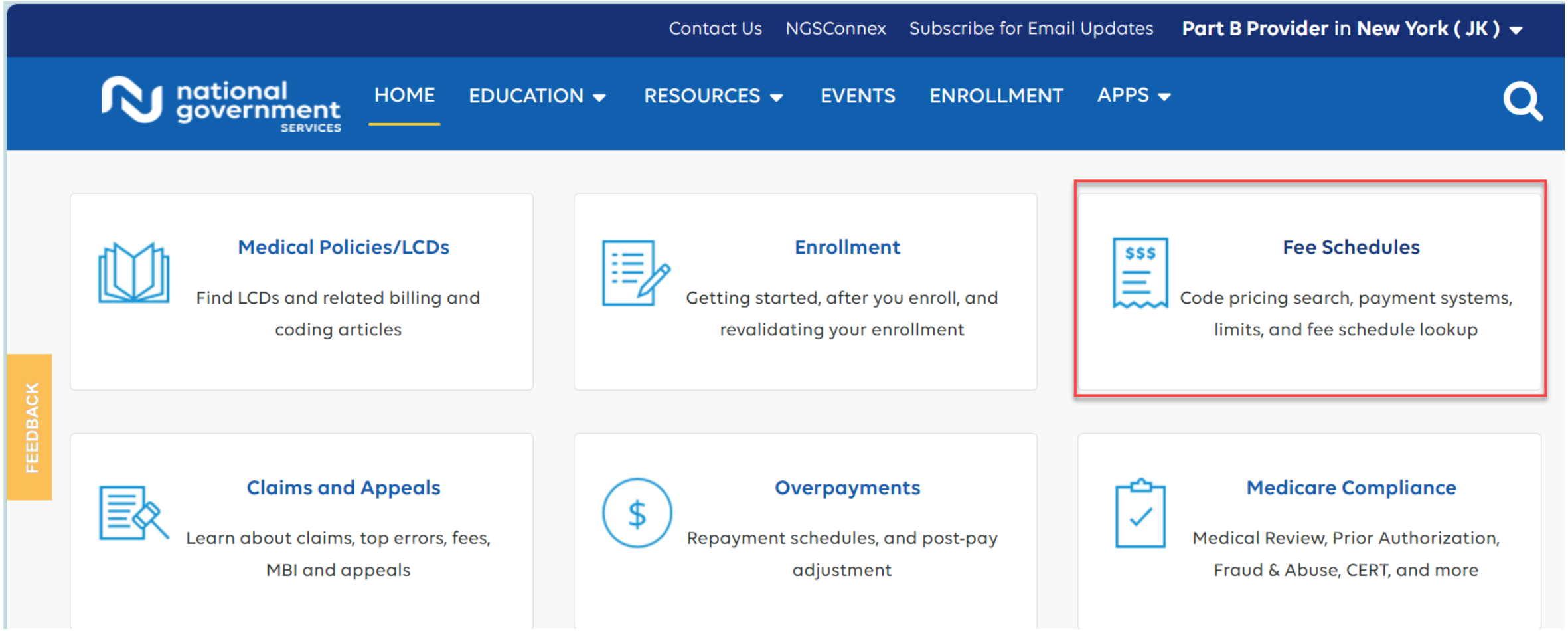
- Pricing
  - Determines reimbursement
  - First field
- Informational
  - Provides additional information regarding service performed but does not affect allowed and/or paid amount
  - Special coverage/informational
  - These modifiers can be placed in any position

Multi-Carrier System

- MCS allows up to four modifiers keyed per claim detail
- Modifier placement on CMS-1500 claim form/electronic equivalent
  - CMS-1500 – Item 24D
  - Electronic equivalent
    - Loop 2400, Field SV101-3, Field SV101-4, Field SV101-5, Field SV101-6
  - Check with your vendor

Fee Schedule

Fee Schedule



Global Days

FEE SCHEDULE LOOKUP

Select a Fee Schedule: * Medicare Physician Fee Schedule Pricing

Result Type: * Full Fee Schedule / Specific To Fee Code

Date of Service: * 06/03/2024

Procedure Code: * 44970

Region: * Rhode Island (area 01)

Search

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	609.56	579.08	665.94	609.56	579.08	665.94

Modifier Selected: (blank)

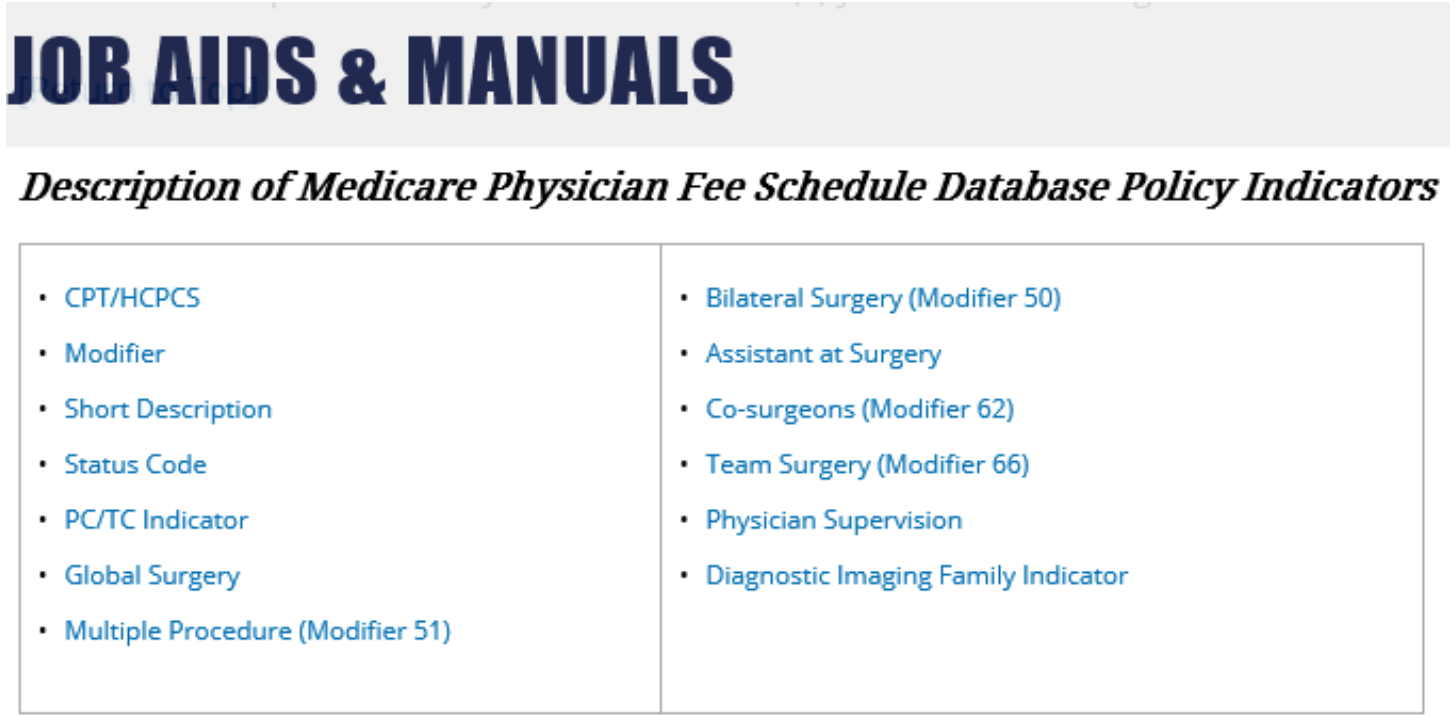
Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
A	33.2875	1.0000	9.45	6.39	6.39
Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
2.34	1.025	1.039	0.849	0.00	
Global Surgery	Facility Pricing	PC/TC	Preoperative Percentage	Interoperative Percentage	Postoperative Percentage
090	1	0	09.00%	81.00%	10.00%

Multiple Surgery	Bilateral Surgery	Assistant At Surgery	Two Surgeons	Team Surgery
2	0	2	2	0

Fee Schedule Assistance

Fee Schedule Assistance

- Provides information about fee schedule definitions and acronyms



Evaluation and Management Modifiers

Modifier 24

- Definition
  - An unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period

Proper Usage

- Append to the E/M procedure code only
- Used for an unrelated E/M service beginning the day after a procedure
- Performed by the same physician during the postop period (10 or 90 days)

Multiple Modifiers on the same E/M

- Example
  - Major surgery performed
  - Patient is seen for an unrelated E/M visit in the aftercare
  - During this unrelated visit a minor surgery or other procedure is performed
- In this case
  - Report modifiers 24 and 25 on the E/M service

Reason for Denial

- Billed on the same day as the procedure
- Used for services related to the surgery such as a complication
- Used on the surgical procedure
- Used for removal of sutures or other wound treatment (part of the surgical package)

Documentation

- Must support that the E/M visit was unrelated to the postoperative care
- Diagnosis should clearly indicate the reason for the unrelated postoperative encounter

Modifier 25

- Definition
  - Significant, separately identifiable evaluation and management service by the *same physician or other qualified health care professional on the same day of the procedure or other service
    - * Physicians in the same group practice who are in the same specialty
    - Must bill and be paid as though they were a single physician

Proper Usage

- Used to indicate that on the same day a procedure or service was performed
  - Condition required significant, separately identifiable E/M service
  - Above and beyond usual pre and postoperative care associated with procedure
  - Different diagnoses are not required
- Bill with an appropriate E/M code
- E/M services are built into the fee components of minor surgical procedures

Example

Date of Service	CPT Code	Diagnosis
2/2/2024	99213 25	Sinusitis
2/2/2024	11400	Incision and drainage of Abscess

Reasons for Denial

- Physician was not the physician who performed the procedure
- Documentation does not support the procedure as a separate and distinct service
- Used on the surgical procedure

Modifier 57

- Definition
  - Decision for surgery: 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

Proper Usage

- E/M services on the day of or on the day before a procedure with a 90-day global period
- Use modifiers 24 and 57 when billing an E/M service resulting in the initial decision to perform major surgery during the postop period of another, unrelated procedure

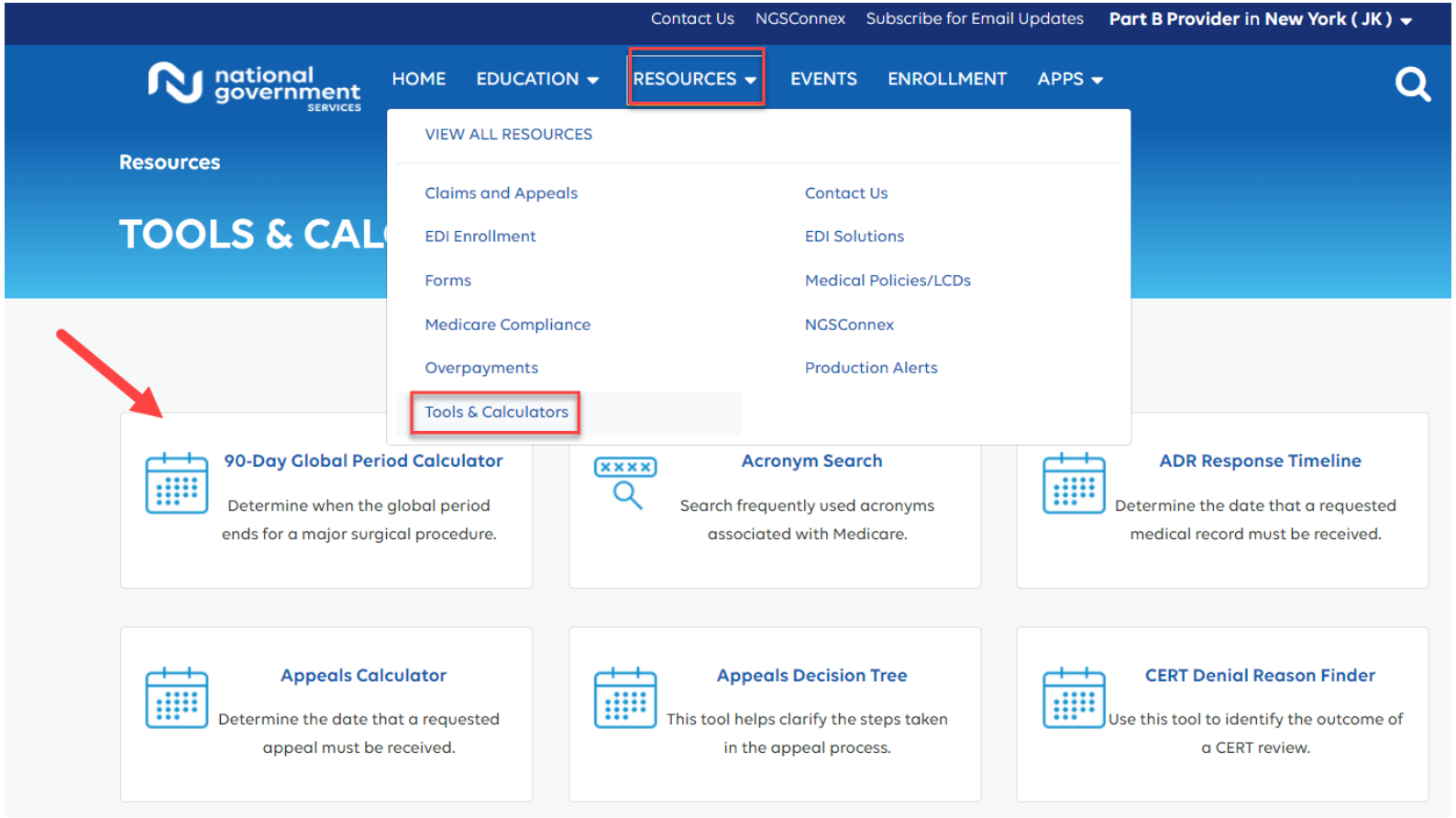
Example

Date of Service	CPT code	Diagnosis Code
5/2/2024	11400	Incision and drainage of abscess
5/8/2024	99214 24 57	Sharp abdominal pain
5/8/2024	44970	Appendectomy

Reasons for Denial

- Not used for the decision for major surgery
- Used on the surgical procedure
- Used for staged surgeries
- Used in connection with a minor surgery

Calculators and Tools



National Correct Coding Initiative Procedure-to-Procedure Coding

What Is the NCCI?

- Developed to promote national correct coding methods
- To control improper coding leading to inappropriate payment for Medicare Part B claims
- Prevent unbundling of services
- Edits are updated quarterly

NCCI Coding

- Column One code is eligible for payment
- Column Two code will be denied unless both codes are clinically appropriate
- Indicate the supporting documentation in the medical record

NCCI Denials

- Beneficiaries cannot be billed
- Cannot use an ABN

NCCI Indicators

Modifier Indicator	Descriptor
Indicator 0	Codes should never be reported together by the same provider/same beneficiary/same DOS
Indicator 1	Codes may be reported together only in defined circumstances (Identified on claims by specific NCCI-associated modifier)
Indicator 9	Not relevant (edit was deleted)

NCCI Examples

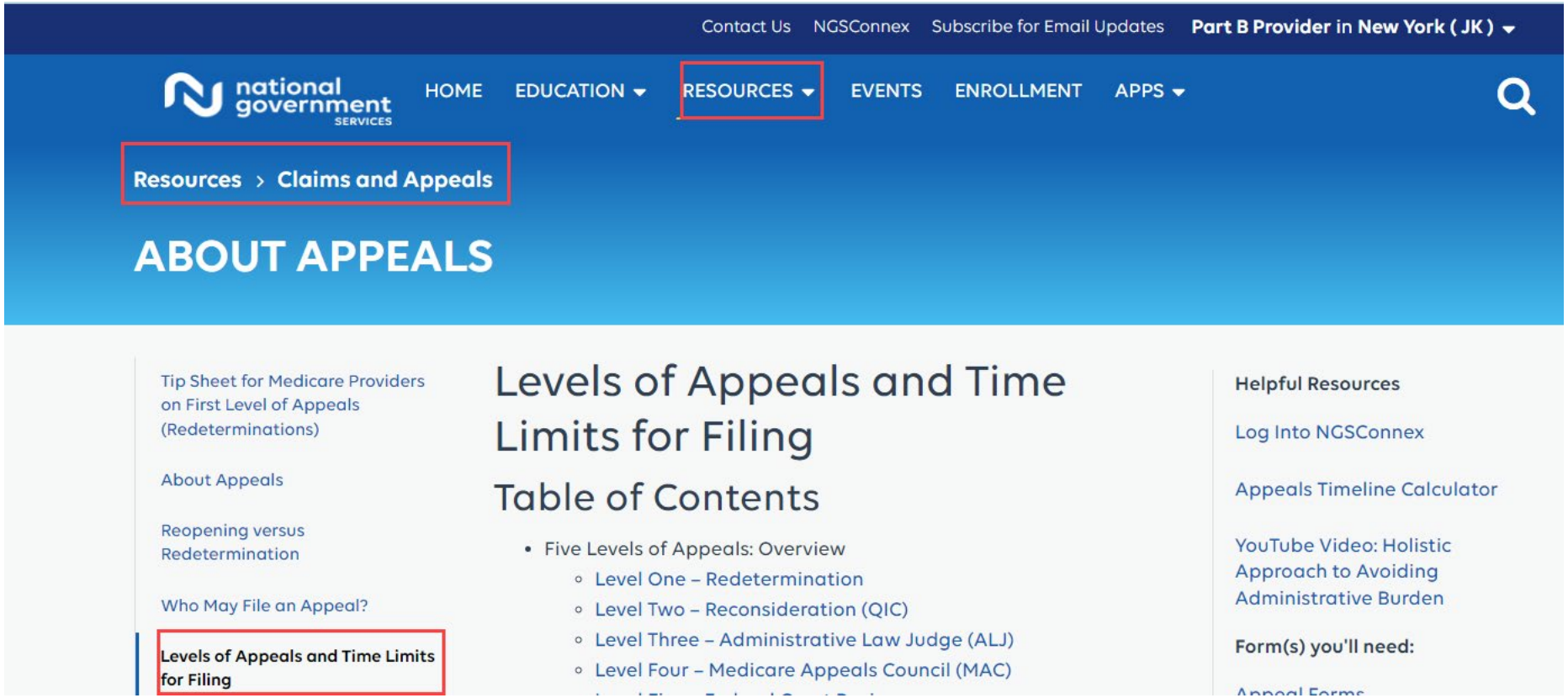
Column 1	Column 2	Prior to 1996	Effective date	Deletion date	Modifiers	PTP Edit Rationale
27047	99215		20130701	*	1	CPT Manual or CMS manual coding instructions
40800	99214		20130701	*	1	CPT Manual or CMS manual coding instructions

Redetermination

Redetermination

- Redetermination – First level of an appeal
  - NGSConnex
  - Written
- No minimum amount in controversy
- Remittance advice code
  - MA01 – Claim has appeal rights
- Attach supporting medical documentation
  - anesthesia reports; operative reports; progress notes; documentation of medical necessity; test results, etc.

Claims and Appeals Homepage



Reopening

Reopening

- Correction to minor, uncomplicated, provider or contractor clerical errors or omissions
  - NGSConnex
  - Telephone
    - TRU line will not process MUE denials
  - Written

Reopening Versus Redetermination

Reopening To correct a claim(s) determination resulting from minor errors	Redetermination (Appeal – First level) For partially paid or denied claim(s) resulting from more complex issues that require analysis of documentation
• Mathematical or computational mistake • Inaccurate data entry • Computer errors • Incorrect data items • Transposed procedure or diagnostic codes	• Coverage of furnished items and service • Overpayment determinations • Medical necessity claim denials • Determination on limitation of liability provision

***Reminder:** TRU line does not accept MUE denials, they must be submitted via NGSConnex portal

Reopening

- Assignment of claims (MAC errors only)
- CLIA certification denials
- Adding or changing order/referring/supervising physician, rendering provider
- Add/change POS changes
- Duplicate denials
- MA plan denials (clinical trial or hospice related only)
- Modifier GV and GW
- Fee schedule incorrect
- HIC/MBI corrections (MAC error only)
- MSP – Medicare now primary
  - **Note**: MSP claims can only be processed within one year from the date of denial or payment

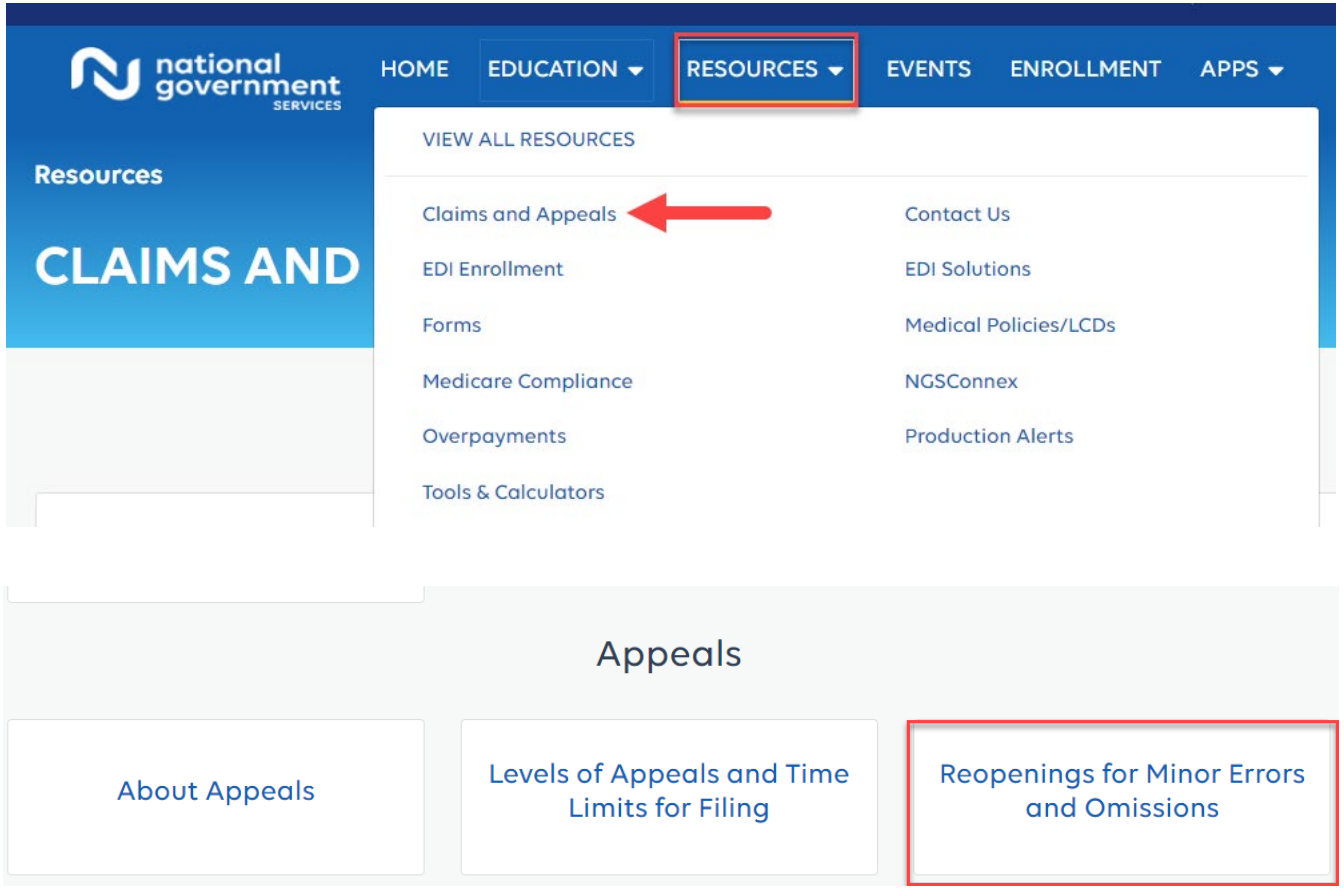
Reopening

- Patient paid amount (MAC error only)
- **Exception:** If Medicaid or another government entity paid in error, please submit a written request
- Adding/changing a modifier
  - Excluding modifiers AQ, AR, QU, QB, 22, 23, 52, 53, 62, 66, GA, GY and GZ (submit redetermination)
- Reopenings for Minor Errors and Omissions

Claims that Cannot Be Reopened

- Adding a line of service (not on the original claim)
- Year of service changes
- An appealed claim
  - Redetermination or reconsideration
- Any claim that requires additional documentation
- Disputing entitlement denials
- Unprocessable/returned/rejected claims
  - RA identified as message MA130

Reopening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Tools & Calculators
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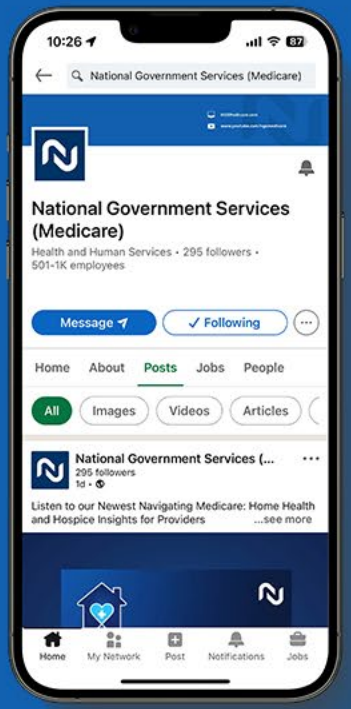
NGSConnex
Production Alerts
Appeals
About Appeals
Levels of Appeals and Time Limits for Filing
Reopenings for Minor Errors and Omissions

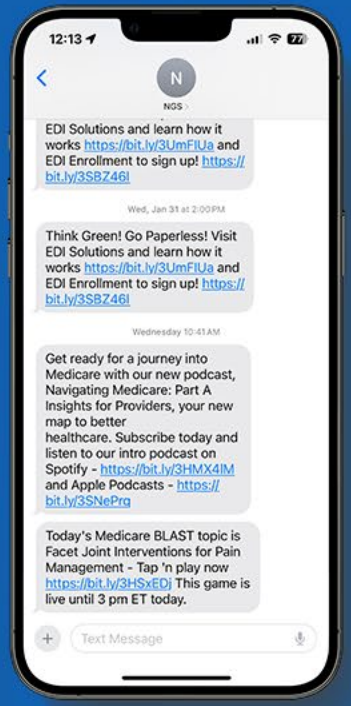
Helpful Tips for Modifier Usage

Situation	Helpful Tips
Modifiers 24 and 25	Appropriate for E/M and eye exam codes (99 series and codes 92002, 92004, 92012, 92014).
Modifier 26	Appropriate for radiology codes (70000–79999), lab (80000–89999).
Modifier 33	Appropriate to identify preventive services when the primary purpose of the service is the delivery of an evidence-based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory).
Modifier 50	To identify procedures done bilaterally. Could be a correction for a claim that was billed with two UOS instead of being billed with one UOS and a 50 modifier.
Modifier 57	Appropriate for E/M and eye exam codes (99 series and codes 92002, 92004, 92012, 92014).

Contacting Telephone Reopening Unit

- Please provide
  - Beneficiary's name
  - Medicare number
  - Your name and phone number
  - Provider's full name/PTAN
  - Item or service in question
  - Date(s) of service in question
  - Reason for request





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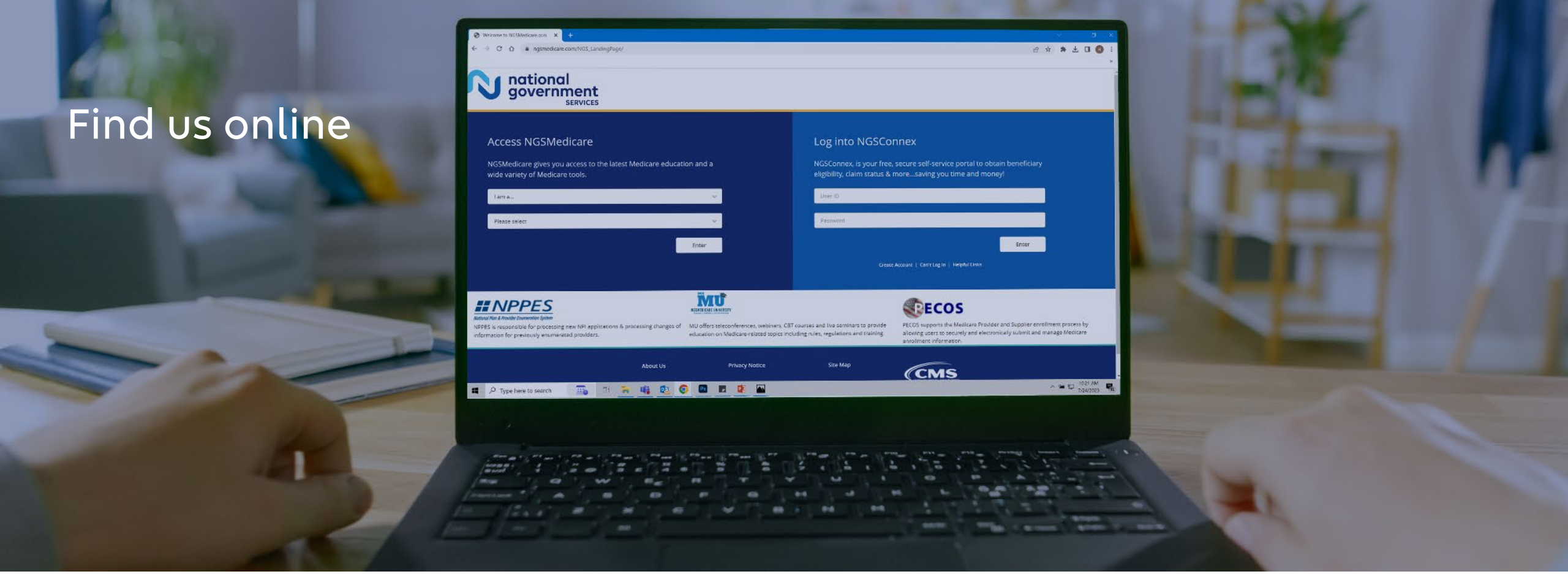

www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

IVR System
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

NGSConnex
Web portal for claim information

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Questions?

Thank you!