

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.*

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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


Contact Us NGSConnex Subscribe for Email Updates **Part B Provider in New York (JK)** ▾

 **HOME** EDUCATION ▾ RESOURCES ▾ EVENTS ENROLLMENT APPS ▾ 




Medical Policies/LCDs

Find LCDs and related billing and coding articles




Enrollment

Getting started, after you enroll, and revalidating your enrollment




Fee Schedules

Code pricing search, payment systems, limits, and fee schedule lookup




Claims and Appeals

Learn about claims, top errors, fees, MBI and appeals



Overpayments

Repayment schedules, and post-pay adjustment



Medicare Compliance

Medical Review, Prior Authorization, Fraud & Abuse, CERT, and more

FEEDBACK

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

JOB AIDS & MANUALS

Description of Medicare Physician Fee Schedule Database Policy Indicators

- | | |
|--|---|
| <ul style="list-style-type: none">• CPT/HCPCS• Modifier• Short Description• Status Code• PC/TC Indicator• Global Surgery• Multiple Procedure (Modifier 51) | <ul style="list-style-type: none">• Bilateral Surgery (Modifier 50)• Assistant at Surgery• Co-surgeons (Modifier 62)• Team Surgery (Modifier 66)• Physician Supervision• Diagnostic Imaging Family Indicator |
|--|---|

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

The screenshot displays the National Government Services website interface. At the top, the navigation bar includes links for 'Contact Us', 'NGSConnex', 'Subscribe for Email Updates', and 'Part B Provider in New York (JK)'. The main navigation menu features 'HOME', 'EDUCATION', 'RESOURCES', 'EVENTS', 'ENROLLMENT', and 'APPS'. The 'RESOURCES' dropdown menu is open, listing various categories such as 'Claims and Appeals', 'ED I Enrollment', 'Forms', 'Medicare Compliance', 'Overpayments', 'Contact Us', 'EDI Solutions', 'Medical Policies/LCDs', 'NGSConnex', and 'Production Alerts'. The 'Tools & Calculators' option is highlighted with a red box. A red arrow points to the 'Tools & Calculators' section on the page, which contains several tool cards:

- 90-Day Global Period Calculator**: Determine when the global period ends for a major surgical procedure.
- Acronym Search**: Search frequently used acronyms associated with Medicare.
- ADR Response Timeline**: Determine the date that a requested medical record must be received.
- Appeals Calculator**: Determine the date that a requested appeal must be received.
- Appeals Decision Tree**: This tool helps clarify the steps taken in the appeal process.
- CERT Denial Reason Finder**: Use this tool to identify the outcome of a CERT review.

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

The background is a solid dark blue color with several overlapping, semi-transparent geometric shapes in lighter shades of blue. These shapes include triangles, rectangles, and rounded forms, creating a layered, abstract pattern. The shapes are positioned primarily on the right side and bottom of the frame, leaving the left side more open for the text.

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

Contact Us NGSConnex Subscribe for Email Updates Part B Provider in New York (JK)

national government SERVICES HOME EDUCATION RESOURCES EVENTS ENROLLMENT APPS

Resources > Claims and Appeals

ABOUT APPEALS

Tip Sheet for Medicare Providers on First Level of Appeals (Redeterminations)

About Appeals

Reopening versus Redetermination

Who May File an Appeal?

Levels of Appeals and Time Limits for Filing

Levels of Appeals and Time Limits for Filing Table of Contents

- Five Levels of Appeals: Overview
 - Level One – Redetermination
 - Level Two – Reconsideration (QIC)
 - Level Three – Administrative Law Judge (ALJ)
 - Level Four – Medicare Appeals Council (MAC)

Helpful Resources

Log Into NGSConnex

Appeals Timeline Calculator

YouTube Video: Holistic Approach to Avoiding Administrative Burden

Form(s) you'll need:

Appeal Forms

The background is a solid blue color with a complex, abstract pattern of overlapping, semi-transparent geometric shapes. These shapes include various polygons, triangles, and rounded rectangles, creating a layered, architectural effect. The colors range from a deep, dark blue to a slightly lighter, medium blue, giving the background a sense of depth and movement.

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
<ul style="list-style-type: none">• Mathematical or computational mistake• Inaccurate data entry• Computer errors• Incorrect data items• Transposed procedure or diagnostic codes	<ul style="list-style-type: none">• 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

The screenshot displays the National Government Services website. The top navigation bar includes links for HOME, EDUCATION, RESOURCES (highlighted with a red box), EVENTS, ENROLLMENT, and APPS. A dropdown menu is open under RESOURCES, listing various resource categories. A red arrow points to 'Claims and Appeals'. Below the navigation, the 'Resources' section is partially visible, showing 'CLAIMS AND'. The main content area features a section titled 'Appeals' with three sub-sections: 'About Appeals', 'Levels of Appeals and Time Limits for Filing', and 'Reopenings for Minor Errors and Omissions' (highlighted with a red box).

national government SERVICES

HOME EDUCATION RESOURCES EVENTS ENROLLMENT APPS

VIEW ALL RESOURCES

Claims and Appeals

EDI Enrollment

Forms

Medicare Compliance

Overpayments

Tools & Calculators

Contact Us

EDI Solutions

Medical Policies/LCDs

NGSConnex

Production Alerts

Resources

CLAIMS AND

Appeals

About Appeals

Levels of Appeals and Time Limits for Filing

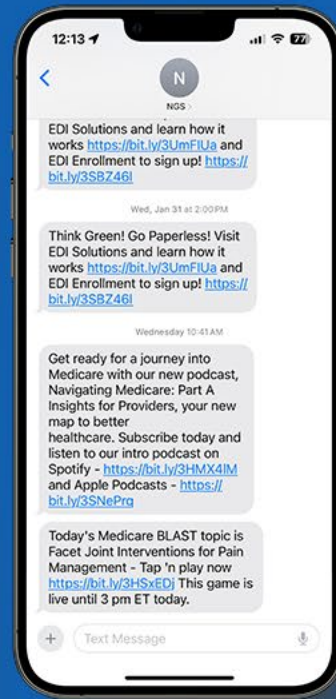
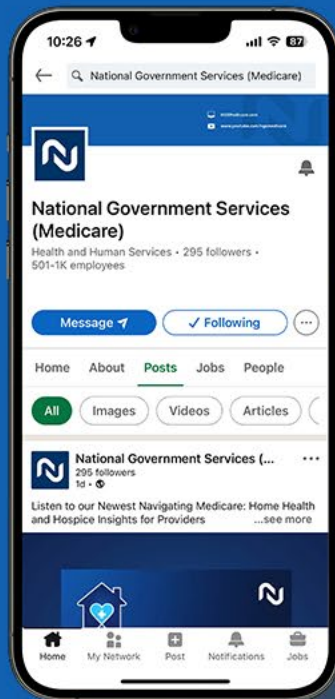
Reopenings for Minor Errors and Omissions

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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Educational Videos



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Self-paced online learning

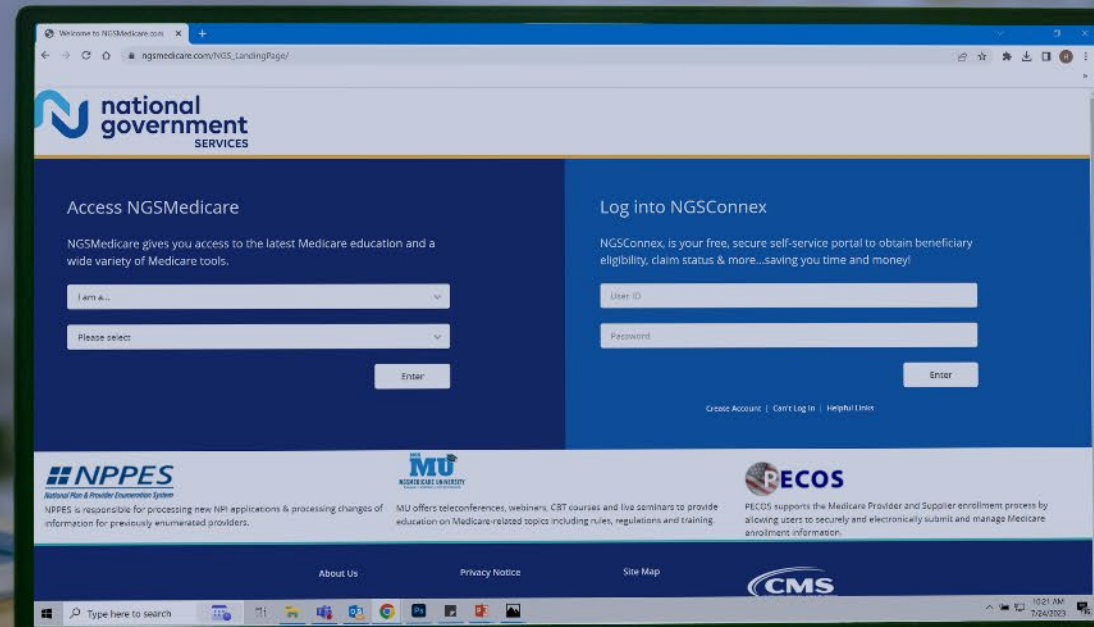
medicare **mobile**

Text NEWS to 37702; Text GAMES to 37702



[LinkedIn](#)
Educational Content

Find us online



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!