

The majority of the new editing applies to services provided by the same physician. Medicare regulation states: "Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician."

### **Modifier use**

- Modifiers should be billed in the following order
  - Pricing modifiers , CCI Modifiers, Informational modifiers, Modifier 99
    - Please note our billing requirements for the 99 modifier vary from that of Medicare. We ask that you place the appropriate modifiers in the first three modifier
- When appropriate, CCI modifiers should be appended to the NCCI column 2 code
- You should ALWAYS use the modifier that most appropriately describes the situation at hand. The 59 modifier should only be used when there is not a more appropriate modifier available
  - Provider offices should verify that the documentation of the situation meets an exception to the CCI edits before using modifier 59.
    - Generally, the 59 modifier should only be used when documentation indicates that two separate procedures were performed on the same date of service by the same physician. Represented by a different session or patient encounter, different procedure or surgery, different site, or separate injury (or area of injury)
    - The 59 modifier should **NOT** be appended for the sole purpose of bypassing an edit.

### **Global Surgery Edits**

- Claims for E/M visits falling in the global surgery period are denying even when 24,25,57 modifiers are appended
  - Modifiers should only be used when the documentation supports that the E/M visit was unrelated to the surgical procedure or the E/M resulted in the decision to perform a major surgery.
    - The 57 modifier cannot be used to bypass global surgery editing when the surgical procedure performed was a minor procedure (000 or 010 GSP).
    - If separately identifiable E/M service falls within both the preoperative the post-operative periods of two or more procedures the E/M visit must be appended with **BOTH** the 24 & 25 modifiers.
  - When the diagnosis indicator for the E/M visit is the same or similar to that of the surgical procedure, documentation will be required. Electronic claims, falling into this scenario, will be denied for documentation.
- Claims for surgical/procedural code falling in the global surgery period of another procedure
  - All surgeries that are performed during the global surgery period of another procedure need to have the appropriate modifier appended to indicate if the procedure is staged, related to the original procedure, or an unrelated procedure.

- Iowa Medicaid policy on the use of the 78 modifier will vary from our local Medicare carrier in that we will allow for use of this modifier on ANY procedural CPT code. Use of this modifier will NOT be limited to codes with 010 and 090 global surgery periods.
- Related procedures are only reimbursed if performed in an operating suite or at the bedside of a critically ill patient. Any related procedure performed outside of these locations is considered as part of the global surgery package for the original procedure and is NOT separately reimbursable.

### **Multiple Units**

- Our process for billing multiple units does vary from that of Medicare, in that you must bill all units on one line.
  - Billing the same CPT code on multiple lines will result in denials of the duplicate lines.
- When exceeding the IME units on CPT codes, providers should append the 51 modifier
  - The 51 modifier should be appended anytime more than 1 unit is billed on a code subject to multiple surgery reductions. (Those codes with a MPFS indicator “2” and “3” codes)
  - On codes that are not subject to multiple surgery reductions, the 51 modifier should **ONLY** be appended when billing more than the IME max units allowed.
- When exceeding the IME units on HCPCS codes, providers should append the GD modifier
- There is additional editing, beyond the IME max units editing, that applies to most CPT codes. This editing applies when more than 1 unit is billed. When billing more than 1 unit you should append the most appropriate modifier to indicate the rationale for the billing of additional units. (this is separate from the 51/GD modifier rule)
- Repeat x-rays should be billed with the 76 modifier. The 76 modifier should **NOT** be used on surgical codes.
- Repeat labs should be billed with the 91 modifier
- Always code the most appropriate/specific modifier that most accurately describes the situation.
  - Anatomic modifiers should be used in place of the 59 modifier, when appropriate.
  - RT/LT/50 modifiers should only be used on CPT codes with a Medicare Physician Fee Schedule bilateral indicator of “1” or “3”
- Documentation will need to be attached whenever the diagnoses/modifiers do not clearly support the medical necessity for the excess units billed.

### **Add-on codes**

- It is highly recommended that you bill both the primary and add-on codes on the same claim form. If the primary code is not paid at the same time, or previous to the add-on code, the add-on code will be denied. Also, if the primary code was denied for any reason, the add-on code will be denied as well.

### **Medicare incidental/bundled codes**

- These codes will always deny when billed on the same date of service as another professional service.
- Modifiers can **NOT** be used to bypass this editing.