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NATIONAL CLINICAL TRAINING CENTER FOR FAMILY PLANNING

Podcast Transcript

Title: Common Modifiers for Billing Family Planning Services
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NCTCFP: Welcome to today's podcast sponsored by the National Clinical Training Center for Family Planning, and part of an ongoing series called "Coding with Ann". The National Clinical Training Center for Family Planning is one of the training centers funded through the Office of Population Affairs to provide training to enhance the knowledge of family planning staff. Our guest speaker is Ann Finn from Ann Finn Consulting LLC. Ann Finn is a healthcare reimbursement consultant and a national trainer with many reproductive health care organizations. Welcome, Ann!

Ann Finn: Thank you. Welcome to my new listeners and welcome back if you have listened to other podcasts in our "Coding with Ann" series. We're excited by the great response from our listeners to date and that we are able to offer these focused coding sessions to provide you with some tips and guidance to ensure you are able to efficiently capture and code for your services – resulting in both timely and accurate revenue.

Today's podcast will focus on the correct use of common modifiers when billing for family planning or contraceptive services. So, let's jump right in.

Modifiers are two digit codes that are characterized into two levels:

1. **Level I Modifiers** are known as CPT Modifiers that consist of two numeric digits and are updated annually by the American Medical Association (or the AMA).
2. **Level II Modifiers** are known as HCPCS Modifiers that consist of two alphanumeric digits in the sequence AA through VP. These modifiers are updated annually by the Centers for Medicare and Medicaid Services (or CMS).

Insurance payers recognize both of these levels of modifiers nationally. Today, we are going to focus on common Level 1 modifiers that are appended to the procedure or CPT code.

Modifiers provide the means by which the reporting clinician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but has not changed in its actual definition or code.

An example of this would be if the clinician is placing an IUD but the patient is experiencing a complication and the insertion procedure is stopped before it is completed. A modifier would be added to the CPT code for the IUD insertion to tell the payer that the procedure being billed was

started but not completed and a reduced payment would be expected for this service in return.

Some modifiers act to reduce the payment for a service as I just mentioned, and some modifiers are used to increase the payment, such as when 2 procedures are billed on the same claim such as an IUD removal and reinsertion, multiple locations of lesion removals, or an evaluation and management medical service along with a Depo injection. From a compliance standpoint, modifiers are essential in order to be reimbursed appropriately for services on your claims. If you submit your claims without the appropriate modifier, if one is needed, you risk receiving either an unintended under- or over-payment for your service, which of course, we want to avoid.

Let's look at a few common modifiers we typically see used in the family planning setting:

1. Modifier 25 is used to describe a "significant and separately identifiable evaluation and management or E/M service by the same clinician on the same day as a procedure or other service."
    a. A few examples of this would include:
        i. Our patient, Amy, presents seeking contraception and the clinician takes a history, reviews all the birth control methods available and other relevant information. After engaging in shared decision-making with the clinician, Amy has an IUD placed during the same visit. We would bill the IUD insertion code 58300 along with the E/M code such as 99203 with a Modifier 25 to tell the payer the E/M is <u>separate and distinct</u> from the IUD insertion. If Amy has a well-woman preventive visit along with the placement of LARC, or long-acting reversible contraception, we would bill the preventive E/M code 99384-99397 along with the appropriate insertion CPT code. But as we've reviewed in our other podcasts, if Amy presents for a scheduled LARC placement, you would not typically code and bill an E/M code as there was no significant and separately identifiable E/M service being provided.
        ii. If Amy presents for birth control, is counseled, and decides on the injectable Depo Provera, the clinician would want to code and bill for the E/M for the medical visit and counseling portion, the injection code 96372, and the Depo drug J1050. The E/M would require a Modifier 25 to be attached to be reimbursed appropriately in addition to the injection code. Without the modifier 25, the E/M would not be paid.
    b. Remember Modifier 25 is used only with E/M codes, not with procedure codes.
2. What if Amy presents and has her old IUD removed and a new one placed? In this case, we would need to bill both the removal and the insertion CPT codes as a pair in order to be paid for the reinsertion services provided. We would also need to add a Modifier 51 Multiple Procedures or a Modifier 59 Distinct Procedure to the second or lower paying procedure code. Be careful, some payers may only recognize one of these modifier codes, and I've seen claims submitted with a modifier that is not recognized by a specific payer and the second service goes unpaid. Also, if you bill two procedures with no modifier attached, the second procedure is typically not paid and you will lose that revenue. A helpful tip is to create a cheat sheet using a grid that indicates payer specifications for all billing staff to use.

3. What if Amy is having an IUD inserted and the clinician needs to stop the procedure due to the patient having a problem such as severe pain or the device is unusable?
    a. In this case, we would still bill for the procedure, but again, we need to append a modifier to tell the payer, "Hey, we attempted the procedure, did a lot of the work, but needed to stop." By appending a Modifier 52 for reduced services because the clinician could not complete the procedure due to an issue such as stenosis, or Modifier 53 for a discontinued service indicating the procedure was discontinued due to extenuating circumstances or a threat to the patient's well-being to the LARC procedure CPT code, and then documenting and coding the appropriate ICD-10 codes to explain any complications, a payer may often reimburse a significant portion of the expected payment for a failed insertion. If you bill for a full insertion and then the patient presents for a second attempted insertion at a following visit, a payer may reject the second claim in full as a duplicate service.
    b. Don't forget Modifier 52 and 53 are used on surgical procedure codes only and are not appended to the E/M codes.
4. What if Amy had an IUD inserted and it was expelled? If the clinician reinserts a new IUD, we would want to append a Modifier 76 - Repeat procedure with same physician or qualified healthcare professional (QHCP) or a Modifier 77 if the repeat procedure was performed by a different clinician. The procedure code is listed once, and then listed again with Modifier 76 or 77 added, which explains that the code billed twice is not a "duplicate."
5. Each procedure code has an expected range of complexity, length, risk, and difficulty. When the service provided exceeds these normal ranges (more complicated, complex, difficult, or requiring significantly more time than usual), then we may add a Modifier 22 to the procedure code. An example of this is if our patient is obese and due to body habitus, or other co-morbidities, the clinician faces difficulties inserting the LARC and the procedure takes much longer than expected. The clinician would document the circumstances and may append a Modifier 22 for Increased Procedural Services. When the use of Modifier 22 is valid, an additional payment may be allowed; however, additional payment consideration may not apply to every code paid. Some payers may also request separate documentation for review. Documenting and coding for co-morbidities that impact the patient's care is important to support instances when you may be able to receive additional reimbursement. Remember, Modifier 22 is used with surgical procedure codes only and not with E/M codes.
    a. Separately, Modifier 21 used to describe prolonged E/M services, was deleted in 2010. Instead, we bill CPT codes 99354-99357 for prolonged E/M services. Check with your payers to determine if these codes are reimbursed and what documentation would be required to support the code.
6. What if Amy receives a LARC during her inpatient delivery hospital stay? In this case, we would want to bill the IUD or implant insertion separately from the delivery or post-partum care. If Jackie had an IUD inserted immediately following the birth, we would bill for insertion using CPT 58300 with a Modifier 51 (multiple procedures) or 59 for "distinct procedure". But what if Amy delivered her baby and the next day before she

left the hospital her midwife or physician placed an implant into her arm as contraception? In this case, we would bill the implant insertion code 11981 with a Modifier 79 Unrelated Procedure or service by the same physician/QHCP during the postoperative period appended. This modifier is typically used 24 hours after the procedure and indicates a separate procedure during the global billing period. We would also bill separately for the expensive LARC device. Again, check with your payers to clarify specific billing policies and reimbursement for post-partum LARC billing.

Let's review a few best practices for billing modifiers correctly:

1. Review the guidelines for using modifiers in the CPT or HCPCS manuals, or other helpful resources. Create billing manuals or tools such as cheat sheets for staff to ensure accurate and consistent modifier usage. Always read the complete description for each modifier to ensure accurate usage.
2. Remember to use the modifiers in effect for the date of service of the claim or they may be rejected on the claim.
3. More than one modifier may be needed and used to accurately bill for a service. Many payers recognize up to three modifiers for a line item on a claim. List the modifiers that impact payment first.
4. Review remittances for denials and unpaid services that may need to be resubmitted with additional information to be paid in full. It is important that your billing staff is trained to understand modifier coding and when modifiers are to be added to a claim. Staff also needs to understand what the expected full payment for a service is so they can recognize when a service is under or over paid. I've reviewed many remittances for providers over the years that were noted as paid by a biller when in fact the service was not reimbursed correctly.
5. If you identify a service that is under-paid, resubmit a corrected claim in a timely manner to ensure full reimbursement is received. On the other hand, if you received an over-payment of a service by not including the correct modifier, it is also important to resubmit and correct the overpayment in a timely manner. Compliant billing practices are key to long term success and avoiding audits and expensive take-backs on mis-billed services.

Modifiers are an essential component to compliant and accurate coding. Contact your specific payers if you have questions about their billing and reimbursement policies or questions pertaining to a particular claim payment.

Thanks for joining us today for our podcast on Common Modifiers used when billing Family Planning Services.

NCTCFP: Thank you, Ann, for this information. To listen to the other podcasts in this series or for more resources on billing and coding in family planning settings, please visit our website www.ctcfp.org, or call us at 1(866) 91-CTCFP - that's 1 (866) 912-8237. A transcript of today's podcast is available for download on our website. Thank you.