

# Productive Provider Newsletter

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## Productive Provider Newsletter

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### Productive Provider Newsletter

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## Front Page

## Its Just My Opinion

It is that time of year again. We are all gearing up for the new coding books for 2006. I don't know about you, but for the past month or so, I have been receiving almost weekly mailings from various publishers and organizations about the 2006 billing and coding books coming out in November.

I always find this to be a fascinating process. A fair number of codes undergo changes every year and so we are obligated to find out which codes have been modified, which have been eliminated, which have been added and so forth. CPT codes get updated every year as do the ICD-9-CM, HCPCS and local insurance company codes.

It is a tedious process to go through the new books and look up the codes we commonly use in our practice and verify their status, but it has to be done. For some practices, it isn't too bad if they have computerized systems that they can simply buy updates for. The question then becomes, "How much does that cost?"

In my contact with various practices and providers, it is not uncommon for me to discover that an office or provider is still using one or more of these books from the previous year. Once, I spoke with an office manager that didn't see a need to buy new books every year (they are expensive). The coding books in that office were three years old. Can you imagine?

*See Opinion on page 2 . . .*

## Modifiers; all those pesky little numbers

You may have discovered that there are times when Evaluation and Management (E/M) codes need a little help or clarification. As complicated as E/M codes are to select, there are times when additional information is needed to fully understand the circumstances under which they occurred. Modifiers were created just for that purpose. It is vitally important to know that use of a modifier DOES NOT guarantee payment for services.

You will find 31 basic (Level I) modifiers listed in Appendix A of the CPT book. Six of them apply directly to Evaluation and Management coding (-21, -24, -25, -32, -52 and -57). The others are used in various areas of medicine, surgery, anesthesia, lab, pathology and radiology. All serve the same purpose; that is, to clarify or to "modify" the usual circumstance of a given patient encounter, service or procedure. The primary purpose of attaching a modifier to any CPT code is to provide additional information to assist with the processing of a claim.

There are eleven Level I modifiers used in outpatient and ambulatory surgery centers. Eight of them are identical to the basic modifiers already mentioned and three (-27, -73 and -74) are unique to outpatient hospital and ambulatory surgical center use.

Another set of modifiers, called Level II Modifiers, have been created for use in outpatient hospital and ambulatory surgical centers which are used to further

*See Modifiers on page 3 . . .*

# M.P.E.C.S.

Understanding Today's  
Healthcare,  
Serving Today's  
Patients,  
Meeting the Needs of  
Today's Practice.

## MARK YOUR CALENDARS

### **PRACTICE PROFITABILITY WORKSHOPS and LECTURES:**

MPECS is dedicated to making your practice of medicine more productive, more profitable and ultimately more enjoyable. The comprehensive MPECS 4-hour **PRACTICE PROFITABILITY** workshop focuses on exactly what you need to know, the specifics of documentation and coding. If you ever find yourself questioning which E/M code you should use, you need this workshop!

**MPECS workshops and lectures** are now being scheduled;

### **UP-COMING MPECS WORKSHOPS;**

**San Antonio, Texas  
November 12, 2005**

**Salt Lake City, Utah  
April 29, 2006**

### **CONFERENCE LECTURES; SUNA Conference** ([www.suna.org](http://www.suna.org))

**Las Vegas, NV  
October 14, 2005**

The MPECS web site lists the specific details for each **workshop** as it becomes available. Check back often. Register **EARLY** for significant workshop discounts.

Need a conference speaker? Give us a call. We'll talk!



## Opinion

Since most codes don't change on a yearly basis, some may feel that it is OK to not update their books yearly. I disagree. When the codes do change and you don't know it, well, then it becomes a problem when you try to bill for the service and then get told that the code you are using is no longer valid or recognized.

I remember one year spending many tedious hours updating our office software and price sheets with new code changes and taking satisfaction in knowing that I had it all done by the first of the year with anticipation that I had headed off problems for that years billings.

Interestingly, within a month or so, we noticed that we were getting some rejections on codes for a particular procedure we were billing in our practice. One particular insurance company informed us more than once that the CPT code we were using wasn't recognized. I opened my CPT book, verified that we were indeed using the correct codes (they had been changed from three codes in the previous book to two new codes in the new book) and instructed the billing manager to contact the insurance company in question to ask them what was going on. We were then informed that their system hadn't been updated with the new codes for that year and that we could resubmit our claims using the old codes or that we could wait another 6-8 weeks when they believed that their systems would be fully updated.

Lesson learned? You bet. Chase down every denial. If you find that an insurance carrier is denying payment for a service you provided to a patient, find out why. File an appeal, make phone calls and figure out what is going on. Once you figure out the problem, make sure that for that payer, you bill it according to their particular requirements. Yes, billing will be different for different payers. That is just the nature of the business. Staying on top of the billings is vital to the success of any practice.

Make sure that you are using current codes. CPT, ICD-9-CM and HCPCS codes need to be accurate and current in every case. If you run into a problem with new or revised codes being recognized by an insurance company, find out why. Don't write it off. It is always worth an investigation, especially if you have been paid previously for a particular code and it is now being rejected.

It's just my opinion.  
Jim Meeks, PA-C

## The Mountain Story

A father was walking with his son in the mountains. Suddenly, the son gets hurt, falls to the ground and screams: "AAAhhhhhhhhhh!!!" To his surprise, he hears a voice repeating, somewhere in the mountain: "AAAhhhhhhhhhh!!!" Curious, he yells: "Who are you?" He receives the answer: "Who are you?" Angered at the response, he screams: "Coward!" He receives the answer: "Coward!" He looks to his father and asks: "What's going on?" The father smiles and says: "My son, pay attention." And then he screams to the mountain: "I admire you!" The voice answers: "I admire you!" Again the man screams: "You are a champion!" The voice answers: "You are a champion!" The boy is surprised, but does not understand. Then the father explains: "People call this ECHO, but really this is LIFE.



## DO YOU KNOW?

Do you know the specific elements of documentation that determine which E/M code you should use? You are not alone if you are still struggling with this process. Never guess again.

Get the **POCKET CODER**.

A pocket sized quick reference that you can easily refer to in the exam room, the hospital, care center or wherever you are seeing patients. Fully comprehensive, covering all practice settings, it will eliminate guesswork and down coding from your practice.

Order yours today online at [www.mpecs.org](http://www.mpecs.org). It is a must for every provider.



## Modifiers

describe certain circumstances of patient encounters. For a complete list of these modifiers, you need a current copy of the Healthcare Common Procedure Coding System or HCPCS Level II book. I really need to stress how important it is to have a current copy of both the HCPCS and CPT books in your practice.

When considering the use of modifiers, providers need to understand that patient encounter documentation needs to support the use of modifiers by correctly reflecting the circumstances that require a modifier in the first place. Lack of adequate medical documentation and/or incorrect usage of modifiers may lead to charges of fraud or abuse. A modifier is the method by which a provider or facility identifies a modification or alteration to a service provided to a patient without changing the basic CPT code used.

For now, I am going to focus on the six modifiers that specifically relate to E/M encounters since that is the focus of training at MPECS. I will discuss three this month and three next month.

### Modifier 21 Prolonged Evaluation and Management Services;

This modifier is used to report face-to-face encounters that last longer than the usual or expected time and apply **only** to the highest level of E/M code within a given area such as office visit for a new (99205) or established (99215) patient. Other areas where this may also be applied include; initial observation care, initial hospital care, subsequent hospital care, observation or inpatient admission and discharge on the same day, office or outpatient consultations, initial inpatient consultations, follow-up inpatient consultations, confirmatory consultations, emergency department services, nursing home encounters, domiciliary, rest home or custodial care service visits, home visits and all preventive medicine visits.

Submitting office notes or a summary report may also be appropriate. The fact that you attach this modifier to an E/M code does not automatically result in a higher payment for the service, especially with Medicare.

If your total face-to-face time with a patient is more than 30 minutes more than the time expected in any of the above mentioned encounters, you should consider using the "Prolonged Services" codes 99354-99357. These are add on codes that may be more appropriate in some circumstances. Additional payment for services may be more likely with these codes.

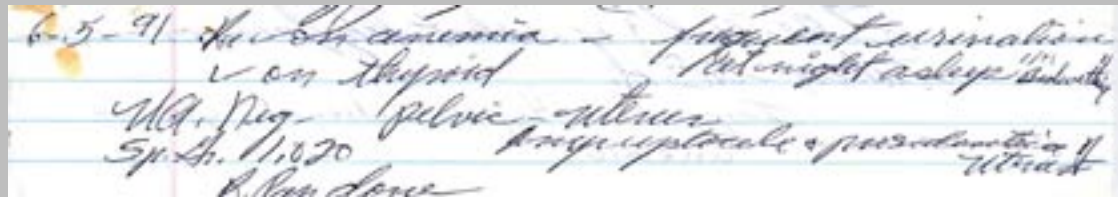
### Modifier 24 Unrelated E/M Service by the Same Physician During a Postoperative Period;

When a provider is paid for a surgical procedure, there is often a block of time following the procedure that falls under the routine care for that procedure and for which no additional charges can be submitted. All follow-up care related to the procedure and performed during this postoperative block of time is included in the payment for the procedure.

Medicare has designated three different periods of time for most procedures: zero days, 10 days and 90 days. Other payers may have different time periods for postoperative care. Providers must know what these postoperative periods of time are for each given procedure and for each insurance carrier they contract with.

If you provide any care during this postoperative block of time that is not associated with the surgical procedure, you should use modifier 24. Otherwise, insurance companies and Medicare assume that any charges submitted during the postoperative period were covered in the payment for the surgical procedure and the claim will most likely be denied.

If you are unsure if the service you are providing is related to the surgical procedure or not, ask yourself this question: "Is the diagnosis code I am using today a different one than was used for the surgical procedure?" If the answer is "yes," then you are probably OK to use modifier 24. This new service must not be related to the surgical procedure.



## Mountain

It gives you back everything you say or do.  
Our life is simply a reflection of our actions.  
If you want more love in the world, create more love in your heart.  
If you want more competence in your team, improve your competence.  
This relationship applies to everything, in all aspects of life;  
Life will give you back everything you have given to it.”

**YOUR LIFE IS NOT A COINCIDENCE. IT'S A REFLECTION OF YOU!**

*Author Unknown*



Fall colors in the mountains near my home just this week. Snow will soon come and we will all look forward to Spring!

## Modifiers

### **Modifier 25 Significant Separately Identifiable E/M Service by the Same Provider on the Same Day of the Procedure or Other Service.**

At first glance, this modifier sounds a lot like the one we just discussed, but it isn't. This one is used when a provider performs some procedure on the same day that a separate Evaluation and Management (E/M) service is provided. It should only be attached to an E/M code, not a surgical or procedural code.

You should be aware that Medicare has instructed their carriers to monitor use of this modifier. Specifically, they are looking for high use of modifier 25 by individual providers or groups. Make sure your use is appropriate and well documented. This modifier should NOT be used on E/M visits that result in the decision for surgery. You should also be aware that a number of third party payers will not recognize modifier 25 on an E/M code when a minor procedure is billed on the same day.

Fortunately, this modifier is fairly self explanatory. If you are seeing a patient for some routine visit, say for hypertension (this could be a new patient or an established patient) and during the visit the patient points out this funny new mole he recently discovered, you may decide to go ahead and do a punch biopsy of the lesion (if you have time).

The biopsy procedure was not the primary reason the patient was being seen, the hypertension evaluation was. This is a key point in the use of this modifier. The E/M visit should be the primary reason the patient came to see you. You must still fulfill the required documentation elements for the E/M visit; history, physical exam and medical decision making. Then, when you have determined the appropriate CPT code for the E/M visit, you attach modifier 25 to declare that it is significant and separately identifiable from the surgical procedure being done on the same day.

You can then submit an additional code for the punch biopsy as a separate charge. Whether the insurance carrier will pay or not depends on their particular interpretation of the CPT codes and their day-to-day standard operating procedures.

Personally, if the patient was being seen for another reason and during the visit brings up an issue that may need a procedure (like a biopsy), I tend to schedule the procedure on another day. This avoids the problem of denials by some insurance carriers and it sure helps my day go a lot smoother if I don't try to squeeze in an extra procedure. Most patients are very understanding when I tell them that I don't want to rush the procedure or get behind with my other patients.

Next month, I'll discuss codes -32, -52 and -57. In the mean time, I recommend the book "Understanding Modifiers" published by Ingenix. It has a lot of detail and some excellent examples of how to use these modifiers correctly. It also points out the incorrect application of modifiers. Their web site is: [www.ingenixonline.com](http://www.ingenixonline.com).

Please visit us on our web site. Go to the **Guest Page** (click on the link at the bottom of any page) and leave your comments or thoughts on this topic or any other you may be interested in seeing discussed here.

MPECS is dedicated to improving your ability to code correctly and with confidence. Let us know how we can help. Visit us at [www.mpecs.org](http://www.mpecs.org).