

MODIFIERS

Modifiers may be added to any CPT code. A general description of modifiers appears in the front of the CPT book as part of the "Introduction" section. A complete listing of modifiers is contained in Appendix A (before the "Index" in the rear of the book). The listings of modifiers pertinent to evaluation and management services, medicine, anesthesia, surgery, radiology, and pathology are located in the guidelines for each of these sections

When you apply modifiers to your procedures and submit claims for same provider/specialty/same group and you submit one claim with no modifiers, then add additional modifiers for the same procedure from the same provider/specialty/same group this is considered a duplicate. Medical records should be reviewed to make sure that documentation is supported. Adding a modifiers to make it "bypass" system edits could be considered Fraud, Waste, or Abuse. Medical documentation must always support the services that were performed.

The Same Day/Same Procedure addresses those instances when a single code should be reported by a physician(s) or other health care professional(s) for multiple medical and/or Evaluation and Management (E/M) services for a patient on a single date of service. Generally, a single E/M code should be used to report all services provided for a patient on each given day.

The Same Specialty Physician or Other Health Care Professional is defined as a physician and/or other health care professional of the same group and same specialty reporting the same Federal Tax Identification number.

The CMS Claims Processing Manual 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. If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Both Initial Hospital Care (CPT codes 99221-99223) and Subsequent Hospital Care codes are "per diem" services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice.

Physicians and qualified non physician practitioners (NPPs) are advised to retain documentation for discretionary contractor review should claims be questioned for both hospital care and critical care claims. The retained documentation shall support claims for critical care when the same physician or physicians of the same specialty in a group practice report critical care services for the same patient on the same calendar date as other E/M services."

The National Correct Coding Initiative Policy Manual states:

“Procedures shall be reported with the most comprehensive CPT code that describes the services performed. Physicians must not unbundle the services described by a HCPCS/CPT code.

A physician shall not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes these services.”

According to correct coding methodology, physicians are to select the code that accurately identifies the service(s) performed. Multiple E/M services, when reported on the same date for the same patient by the same specialty physician, will be subject to edits used by and sourced to third party authorities. As stated above, physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

According to the CPT® book "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service)..." **Modifier 25**

Example: 2 visits same provider/qualified healthcare profession or same specialty/same day/same patient 1st claim comes through no modifier, 2nd claim all matches except they tossed on Modifier 25, these are considered duplicates. Only one E/M should be reported adding the modifier to the second does not support separate identifiable services.