



Applicable To:

- Medicaid
- Medicare

Claims Edit Guideline: Procedure to Procedure Associated Modifiers

Policy Number: HS-293

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BACKGROUND

Healthcare providers utilize Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes to report medical services conducted on patients for accountability and reimbursement. Healthcare Common Procedure Coding System (HCPCS) consists of Level I CPT (Current Procedural Terminology) codes and Level II codes. CPT codes are defined in the American Medical Association's (AMA's) CPT Manual which is updated and published annually. HCPCS Level II codes are defined by the Centers for Medicare & Medicaid Services (CMS) and are updated throughout the year as necessary. Changes in CPT codes are approved by the AMA CPT Editorial Panel which meets three times per year.

CPT and HCPCS Level II codes define medical and surgical procedures performed on patients. Because many procedures can be performed by different approaches, different methods, or in combination with other procedures, there are often multiple HCPCS/CPT codes defining similar or related procedures. CMS developed National Correct Coding Initiatives (NCCI) to prevent inappropriate payment of services that should not be reported together. NCCI Procedure To Procedure (PTP) edits are placed into the "Column One/Column Two Correct Coding Edit Table. The edit table contains edits which are pairs of HCPCS/CPT codes, which in general, should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair, the column two code is denied, and the column one code is eligible for payment. However, if it is clinically appropriate to utilize an NCCI (PTP)-associated modifier, both the column one and column two codes are eligible for payment.

CPT and HCPCS Level II code descriptors usually do not define all services included in a procedure. There are often services inherent in a procedure or group of procedures. Many National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edits are based on the clinical standards of medical/surgical practice. It is very important that PTP-associated modifiers only be used when appropriate. In general these circumstances relate to separate patient encounters, separate anatomic sites or separate specimens.

CPT and HCPCS Modifiers are utilized to provide additional clarification for the service performed without changing the definition of the code. This allows a way to alter the service without changing the procedure code. Some modifiers impact how a procedure is reimbursed; since data integrity and reimbursement can be impacted, WellCare utilizes a

variety of sources to identify and apply appropriate editing and monitoring for CPT and HCPCS codes billed with PTP modifiers.

Most commonly used modifiers 59 and 25 along other PTP-associated modifiers should NOT be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any PTP associated modifier that is used.

Modifier 25

Description: Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service

Guidelines

- Documentation in the patient's medical record must support the use of this modifier. The CPT description for this modifier specifies that a significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M services to be reported.
- The E&M service may be related to the same or different diagnosis as the other procedure(s).
- This modifier may be used to indicate that an E/M service was provided on the same day as another procedure that would normally bundle under NCCI. In this situation, CPT modifier 25 signifies that the E/M service was performed for a reason unrelated to the other procedure.
 - Code pairs identified with indicator 9 are not subject to NCCI edits; modifier not required in these situations.
- Modifier 25 may be appended to E&M services reported with minor surgical procedures (global period of 000 or 010 days) or procedures not covered by global surgery rules (global indicator of XXX).
- Since minor surgical procedures and XXX procedures include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider shall not report an E&M service for this work.
- Medicare Global Surgery rules prevent the reporting of a separate E&M service for the work associated with the decision to perform a minor surgical procedure whether the patient is a new or established patient
- To determine the global period of a surgery, refer to the Medicare Physician Fee Schedule database (MPFSDB) directly from the [CMS website](#).

Modifier 59

Description: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.

Guidelines:

- Modifier 59 is an important PTP associated modifier that is often used incorrectly. Its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters. One function of PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are "separate and distinct."
- Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.
- When another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

PTP edits are based on services provided by the same provider to the same member on the same date of service.

Modifiers that may be used under appropriate clinical circumstances to bypass a PTP edit include:

- Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
- Global surgery modifiers: 24, 25, 57, 58, 78, 79
- Other modifiers: 27, 59, 91, XE, XS, XP, XU

Each PTP edit has an assigned modifier indicator.

- A modifier indicator of “0” indicates that NCCI-associated modifiers cannot be used to bypass the edit.
- A modifier indicator of “1” indicates that NCCI-associated modifiers may be used to bypass an edit under appropriate circumstances.
- A modifier indicator of “9” indicates that the edit has been deleted, and the modifier indicator is not relevant.

POSITION STATEMENT

Wellcare utilizes Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative, Claims Processing Manual, ICD-10-CM Conventions, along with other clinical coding guidelines in determining correct coding and reimbursement for procedure to procedure associated modifiers. An additional layer of clinical editing may apply post claim adjudication that requires a request for submission of medical records.

CODING

Modifiers are added to CPT procedural codes to provide additional information and clarification of the specific service provided. The following tables outlines description of modifiers that may be used under appropriate clinical circumstances to bypass a PTP edit:

Global Surgery Modifiers

Modifier	Description	Definition
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period	The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.
25	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	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.
57	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.
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the	It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding

	Postoperative Period	modifier 58 to the staged or related procedure.
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period	It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure.
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional	The provider may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79

Anatomical Modifiers

Modifier	Description	Definition
E1-E4	Eyelid	E1=Upper left E2=Lower left E3=Upper right E4=Lower right
FA	Thumb	Left hand, thumb
F1-F9	Hand	F1=Left hand, 2nd digit F2= Left hand, third digit F3= Left hand, 4th digit F4= Left hand, fifth digit F5= Right hand, thumb F6= Right hand, 2nd digit F7= Right hand, 3rd digit F8= Right hand, 4th digit F9= Right hand, 5th digit
TA	Foot	Left foot, great toe
T1-T9	Foot	T1= Left foot, 2nd digit T2= Left foot, 3rd digit T3= Left foot, 4th digit T4= Left foot, 5th digit T5= Right foot, great toe T6= Right foot, 2nd digit T7= Right foot, 3rd digit T8= Right foot, 4th digit T9= Right foot, 5th digit
LT	Anatomical site=Body	Left side (used to identify procedures performed on the left side of the body)

RT	Anatomical site=Body	Right side (used to identify procedures performed on the right side of the body)
LC	Coronary Artery	Left circumflex coronary artery
LD	Coronary Artery	Left anterior descending coronary artery
RC	Coronary Artery	Right coronary artery
LM	Coronary Artery	Left main coronary artery
RI	Coronary Artery	Ramus intermedius coronary artery

Other Modifiers

Modifier	Description	Definition
27	Multiple Outpatient Hospital E/M Encounters on the Same Date	For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (i.e. hospital emergency department, clinic). Note: This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date
59	Distinct Procedural Service	Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.
91	Repeat Clinical Diagnostic Laboratory Test	In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (i.e. glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

XE	Distinct Service	Separate encounter, a service that is distinct because it occurred during a separate encounter
XS	Distinct Service	Separate structure, a service that is distinct because it was performed on a separate organ/structure
XP	Distinct Service	Separate practitioner, a service that is distinct because it was performed by a different practitioner

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES

1. National Correct Coding Initiative Edits. Centers for Medicare and Medicaid Services Web site. <https://www.cms.gov/Medicare/Coding/NationalCorrectCodingInitEd/index.html>. Accessed October 8, 2018.
2. Physician Fee Schedule. Centers for Medicare and Medicaid Services Web site. <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>. Accessed October 8, 2018.
3. Current Procedural Terminology (CPT®). American Medical Association Web site. <https://www.ama-assn.org/practice-management/cpt>. Accessed October 8, 2018.

LEGAL DISCLAIMER

The Claims Edit Guideline (CEG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CEG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this CEG. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the CEG. Additionally, CEGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CEG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

*Easy Choice Health Plan – Missouri Care – Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona
OneCare (Care1st Health Plan Arizona, Inc.) – Staywell of Florida – WellCare Prescription Insurance – WellCare Texan Plus (Medicare – Dallas and Houston markets)
WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)*

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	Action
11/1/2018	<ul style="list-style-type: none"> • Approved by MPC. No changes.
12/22/2017	<ul style="list-style-type: none"> • Approved by MPC. New.