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Modifier Mania

Did you know Medicare Administrative Contractors (MAC's) are required by CMS to publish educational releases and use other established means to provide you billing and payment information? While some of these guidelines may be carrier specific, information on how a MAC interprets the CMS processing requirements can include information from CMS that may be applicable to all Medicare practices. National Government Services (NGS) is the MAC for Medicare Jurisdiction K, which includes the New York and New England states. NGS recently issued a policy education notice¹ that is a great reminder on Medicare's guidelines for Anesthesia Modifiers.

There are three classifications of modifiers. The first, sometimes referred to as **anesthesia pricing modifiers**, should always be listed in the first position after the anesthesia code. These modifiers may affect the payment for the service rendered. Anesthesia pricing modifiers include the following:

AA – Anesthesia services performed personally by the anesthesiologist.
(These services are paid at 100% of the Medicare fee schedule.)

AD – Medical supervision by a physician; more than 4 concurrent anesthesia procedures.
(These services are paid per the supervision policies of the carrier. Medicare allows three base units per procedure. An additional time unit may be recognized if the physician can document presence at induction.)

QK – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.
(These services are paid per the medical direction policies of the carrier. Medicare will pay 50% of the allowed amount to the directing physician anesthesiologist.)

QX – Qualified nonphysician anesthetist with medical direction by a physician.
(These services are paid per the medical direction policies of the carrier. Medicare will pay 50% of the allow amount to the CRNA or Anesthesiologist Assistant.)

QY – Medical direction of one qualified nonphysician anesthetist by an anesthesiologist.
(These services are paid per the medical direction policies of the carrier. Medicare will pay 50% of the allowed amount to the directing physician anesthesiologist.)

¹ NGS Policy Education Topics: Anesthesia Modifiers, release date October 31, 2016.

QZ – CRNA without medical direction by a physician.
(These services are paid at 100% of the Medicare fee schedule.)

While this modifier (QZ) was omitted from the NGS October 31, 2016 education policy notice, it is a valid Medicare modifier and listed in the NGS Anesthesia Billing Guide².

If the correct modifier is not attached or if the anesthesia pricing modifier is not in the first modifier position, your payment may be affected.

Preventative screening modifiers are the second classification. The Affordable Care Act Section 4104 waives the coinsurance for any services defined as preventative services, including colorectal cancer screening tests. The CY2015 Medicare Physician Fee Schedule final rule revised the definition of the colorectal cancer screening tests to include any anesthesia separately furnished in conjunction with screening colonoscopies³. The preventative screening modifiers identify anesthesia services for screening colonoscopies. These modifiers should be placed in the second modifier position if applicable to the anesthesia service. The two modifiers in this class are:

33 – Preventative service: when the primary purpose of the service is the delivery of an evidence based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory). This modifier should be added to anesthesia CPT 00810 when anesthesia for a screening colonoscopy is performed. It should be placed in the second modifier position to waive both the Medicare deductible and any coinsurance.

PT – A colorectal cancer screening test which led to a diagnostic procedure. This modifier can be appended to anesthesia CPT 00810 in the second modifier position if applicable and it will waive the Medicare deductible for this service.

Not applying either of the preventative services modifiers in the correct position may affect your payment as well as the charges billed to the patient.

The third class of modifiers is the **informational modifiers**. While these modifiers do not change the service or the payment, they provide information about how or where the service was rendered. These modifiers should be placed in the third or last position, depending on what other modifiers are used. Examples of informational modifiers are:

² NGS Job Aids & Manuals: Anesthesia Billing Guide, accessed November 11, 2016.

³ MLN Matters #MM8874, release date April 3, 2015.

Timely Topics

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QS – Monitored anesthesia care service.

G8 – Monitored anesthesia care for deep complex, complicated or markedly invasive surgical procedures.

(This modifier may be used in lieu of modifier QS.)

G9 – Monitored anesthesia care for a patient who has a history of severe cardiopulmonary condition.

(This modifier may be used in lieu of modifier QS.)

GC – Performed by a resident under the direction of a teaching physician. This modifier is reported by the teaching physician to indicate the service was rendered in compliance with Medicare's teaching physician requirements. The provider must also use one of the other pricing modifiers in the first modifier position.

AQ – Services provided in a Health Professional Shortage Area (HPSA).

23 – Unusual anesthesia. While Medicare recognizes this modifier, there is no payment adjustment when it is appended.

Physical status modifiers are not recognized by Medicare. NGS instructs providers that if they choose to bill with the physical status modifiers, they should be listed in the last position as an informational modifier only. However, many commercial carriers and some Medicaid programs will allow the modifiers and will pay additional base units depending on the physical status of the patient. Physical status modifiers are outlined in the American Society of Anesthesiologists' Relative Value Guide®⁴:

P1 – A normal healthy patient.

P2 – A patient with mild systemic disease.

P3 – A patient with severe systemic disease.

P4 – A patient with severe systemic disease that is a constant threat to life.

P5 – A moribund patient who is not expected to survive without the operation.

P6 – A declared brain-dead patient whose organs are being removed for donor purposes.

There are additional payment modifiers applicable to anesthesia and/or pain medicine services:

25 – Significant, separately identifiable E&M service. This modifier is appended to the evaluation and management (E&M) code when the same provider renders such service in addition to another procedure or service on the same day. There can be confusion between some of the elements typically considered part of the pre- and post-procedural work for procedures that overlap with elements required in E&M

⁴ American Society of Anesthesiologists, 2016 Relative Value Guide, p xiii

services. However, for E&M services to be considered significant and separately identifiable, the service must be medically necessary and beyond the scope of services routinely provided as part of the procedure. As an example, the separately identifiable service might be to evaluate an additional complaint, that is appropriately documented and can stand on its own—separately from the services related to the procedure⁵.

59 – Distinct procedural service. This modifier is appended to a procedure code to identify that it is separate and distinct from other services billed that normally would be bundled together. It is the most commonly used modifier, sometimes inappropriately. Modifier 59 can be used to identify services that are appropriate for additional payment and override procedure-to-procedure (PTP) edits developed as part of Medicare’s National Correct Coding Initiative (NCCI). Appropriate uses of this modifier include appending it to services that are done at a different time or encounter, on a different body area, by a different provider, and/or for a different reason, eg, a diagnostic procedure prior to a therapeutic procedure⁶. Modifier 59 should not be used if a more specific modifier is available.

The following modifiers became effective January 1, 2015. They may be used instead of modifier 59, but are not required. Future updates to NCCI PTP edits may require more specificity in modifier usage prior to allowing additional payment for normally bundled services⁷ and these modifiers will provide that additional information.

XE – Separate encounter, a service that is distinct because it occurred during a separate encounter.

XS – Separate structure, a service that is distinct because it was performed on a separate organ/structure.

XP – Separate practitioner, a service that is distinct because it was performed by a different practitioner.

XU – Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

Each modifier serves a unique purpose. Reviewing your MAC’s guidelines on how to use and apply each modifier could impact your billing and your payments. Medicaid and Commercial payers often provide their own requirements, interpretations and guidance on modifier usage.

⁵ NGS Policy Education Topics: Modifier 25, accessed November 10, 2016.

⁶ CMS Modifier 59 Article, p 3, accessed November 10, 2016.

⁷ MLN Matters #MM8863, release date August 15, 2014.