**Applicable To:**

- ☑ Medicare
- ☑ Medicaid – excluding Arizona and Kentucky
- ☑ Florida CMS Health Plan

# Claims and Payment Policy:
## PROCEDURE TO PROCEDURE ASSOCIATED MODIFIERS

**Policy Number: CPP-127**

**Original Effective Date: 12/22/2017**
**Revised Effective Date(s): 11/1/2018**

## 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.


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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.


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- 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 & BILLING

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. |


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| **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 Postoperative Period | 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 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<br>E2-Lower left<br>E3-Upper right<br>E4-Lower right |
| **FA** | Thumb | Left hand, thumb |
| **F1-F9** | Hand | F1=Left hand, 2nd digit<br>F2= Left hand, third digit<br>F3= Left hand, 4th digit<br>F4= Left hand, fifth digit<br>F5= Right hand, thumb<br>F6= Right hand, 2nd digit<br>F7= Right hand, 3rd digit<br>F8= Right hand, 4th digit<br>F9= Right hand, 5th digit |
| **TA** | Foot | Left foot, great toe |
| **T1-T9** | Foot | T1= Left foot, 2nd digit<br>T2= Left foot, 3rd digit<br>T3= Left foot, 4th digit<br>T4= Left foot, 5th digit<br>T5= Right foot, great toe |


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| | | T6= Right foot, 2nd digit<br>T7= Right foot, 3rd digit<br>T8= Right foot, 4th digit<br>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 |


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| | | 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/NationalCorrectCodInitEd/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.

## IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.
The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.
References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.wellcare.com. Select the "Provider" tab, then "Tools" and then "Payment Guidelines".


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## RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

| Date | Action |
|---|---|
| 10/30/2019 | • Approved by RGC |


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