


Acute Care Surgery Billing, Coding and Documentation Series Part 3: Coding of Additional Select Procedures; Modifiers; Telemedicine Coding; Robotic Surgery

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SUMMARY

This series of reviews has been produced to assist both the experienced surgeon and coder, as well as those just starting practice that may have little formal training in this area. Understanding this complex system will allow the provider to work “smarter, not harder” and garner the maximum compensation for their work. We hope we have been successful in achieving and that goal that this series will provide useful information and be worth the time invested in reading it by bringing tangible benefits to the efficiency of practice and its reimbursement. This third section deals with coding of additional select procedures, modifiers, telemedicine coding, and robotic surgery.

CODING OF ADDITIONAL PROCEDURES

Ultrasound

Practitioners must provide documentation via the physical examination to support diagnostic. While the medical record or ultrasound report is not required to be submitted with the claim, third-party payers may request to review this material at any time. Meticulous documentation is required to support claims and, in case of an audit, to avoid refunds and/or penalties. In all reporting of ultrasound services in the hospital setting, the physician's professional service is identified by appending the 26 modifier to the appropriate CPT code, that is, 36556, 76937–26. This indicates to the payers that the professional component of the ultrasound service, which encompasses the supervision and interpretation elements, has been provided.

CPT Code and Description

CPT 76937: *Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting*

CPT 76604: *Ultrasound, chest (includes mediastinum), real time with image documentation*

CPT 76942: *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation.*

This is billed with either

32421—*Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent*

OR

32422—*Thoracentesis, with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)*

CPT 33016 has been added for pericardiocentesis and includes imaging guidance when performed. Codes 33010, 33011, 33015, and 76930 should no longer be used.

CPT 75989: *Radiological guidance (ie, fluoroscopy, ultrasound or CT) for percutaneous drainage (eg, abscess, specimen collection).* This is billed with either

32550—*Insertion of indwelling tunneled pleural catheter with cuff*

OR

32551—*Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure)*

CPT 76705: *Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)*

CPT 76775: *Ultrasound, retroperitoneal (eg, renal, aorta, nodes) real time with image documentation; limited*

CPT 93308: *Echocardiography, transthoracic, real time with image documentation (2D), includes M-mode recording, when performed; follow-up or limited study*

Payment for ultrasound services performed in the hospital inpatient ICU

Charges for the ultrasound services occurring in the hospital inpatient setting are considered part of the charges submitted for the inpatient stay and payment is made under the Medicare MS-DRG payment system. However, providers may still submit a bill for professional services. Medicare reimburses for ultrasound services when the services are within the scope of the provider's license and are deemed medically necessary. Some payers will reimburse ultrasound procedures to all specialties while other plans will limit reimbursement for ultrasound procedures to specific types of medical specialties.

Associated ICD-10 diagnosis coding and documentation

It is essential that each claim be coded appropriately and supported with adequate documentation in the medical record.



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Due to the many ICD-10-CM Diagnosis Codes which may be associated with any one Procedure Code, it is best to confirm with the payer which ICD-10-CM diagnosis code is most appropriate to assure payment.

Documentation requirements

Ultrasound performed using either a compact portable ultrasound or a console ultrasound system are reported using the same CPT codes as long as the studies that were performed meet all the following requirements: medical necessity as determined by the payer; completeness; documentation in the patient's medical record.

A separate written record of the diagnostic ultrasound or ultrasound-guided procedure must be completed and maintained in the patient record. This should include a description of the structures or organs examined and the findings and reason for the ultrasound procedure(s). Diagnostic ultrasound procedures require the production and retention of image documentation. It is recommended that permanent ultrasound images, either electronic or hardcopy, from all ultrasound services be retained in the patient record or other appropriate archive.

In addition, there are plans that require providers to submit applications requesting these services be added to the list of services performed in their practice. It is important that the payer be contacted prior to submitting claims to determine their requirements.

RESUSCITATIVE ENDOVASCULAR BALLOON OCCLUSION OF THE AORTA (REBOA)

The recommended coding for the REBOA catheter is CPT 37244 with modifier 52. Modifier 52 is currently recommended since the REBOA is a temporary occlusion device and not a permanent occlusion device which is what is described by CPT 37244. Code 37244 also includes all image guidance.

Incision and drainage procedures

Abscesses are divided into two types, simple and complex. Simple incision and drainage without packing is coded with 10060. A complex abscess generally requires a drain or packing and the CPT code for this is 10061. Drainage of hematomas, seromas or fluid collections are described by CPT code 10140. Complex wounds which require drainage and excision of tissue with packing or drain placement are coded using CPT 10180.

For additional information on this topic, see the following resources:

- ▶ <https://www.todayshospitalist.com/tips-to-choose-the-right-codes-for-incision-and-drainage/> (accessed July 1, 2020)
- ▶ <https://www.angiodynamics.com/img/documents/2020-Vascular-Access-Reimbursement-Coding-Guide-USVAMS75Rev01-600629.pdf> (accessed May 19, 2020)

MODIFIERS

Modifiers are crucial to explain that a procedure or service was changed or altered without changing the core definition of the CPT code(s) submitted. Each modifier has specific guidelines for use and documentation necessary to support its application. Some common modifiers related to E/M and procedural services and their CPT codes follow.

22 Modifier

This modifier is used to indicate an increased procedural service. That is, the procedure involved more work, was more difficult

and/or took substantially more time than typically required. These are the guidelines for its application to a CPT code:

- ▶ This modifier may only be reported with procedure codes that are specified as having a 0, 10 or 90-day global period.
- ▶ This modifier may not be submitted with evaluation and management (E/M) procedures.
- ▶ Documentation required with the claim:
 - A concise statement *and* operative report
 - The concise statement should be entered in the EMR. The concise statement may appear on the operative report, but it must be clearly identified. This is best done with a separate statement.
 - Services that are submitted with CPT modifier 22 that do not meet these requirements will not be considered for additional reimbursement and failure to submit the appropriate information will result in a denial of the claim.

24 Modifier

This modifier denotes an unrelated E/M service by the same physician during a postoperative period and must be added to E/M charges if patient is seen for a diagnosis unrelated to the surgical procedure.

Medicare defines same physician as physicians in the same group practice who are of the same specialty (NPI). In this instance, they must bill and be paid as though they were a single physician.

Modifier 24 is applied to E/M services (99201–99499).

Appropriate use

- ▶ Use Modifier 24 on an appropriate level of E/M service when
 - An unrelated E/M service is performed beginning the day after the procedure, by the same physician, during the 10 or 90-day postoperative period.
 - Documentation indicates the service was exclusively for treatment of the underlying condition and not for postoperative care.
 - Unrelated critical care performed by the same physician during the postoperative period.
 - The same diagnosis as the original procedure could be used for the new E/M if the problem occurs at a different anatomical site.

Inappropriate use

- ▶ Do not use Modifier 24 when
 - The E/M is for a surgical complication or infection. This treatment is part of the surgery package.
 - The service is removal of sutures or other wound treatment. This treatment is part of the surgery package.
 - The surgeon admits a patient to a skilled nursing facility for a condition related to the surgery.
 - The medical record documentation clearly indicates the E/M is related to the surgery.
 - Outside of the postoperative period of a procedure. Services are rendered on the same day as the procedure.
 - Reporting examinations performed for routine postoperative care.

25 Modifier

A 25 modifier is needed for unrelated E/M services performed on the same day as a procedure, including zero day global surgical package procedures.

Should a separately identifiable E/M service be provided on the same date that a diagnostic and/or therapeutic procedure(s)

is performed, information substantiating the E/M service must be clearly documented in the patient's medical record, to justify use of the modifier 25.

26 Modifier

For the Acute Care Surgeon, this is most commonly used in conjunction with the performance of an ultrasound examination. A physician who performs the interpretation of an ultrasound examination in the hospital outpatient setting may submit a charge for the professional component of the ultrasound service using a modifier 26 appended to the ultrasound code. See the section on ultrasound for more information on use of modifier 26 and the use of CPT procedure codes in the inpatient setting.

50 Modifier

This modifier describes procedures/services that occur on identical, opposing structures (eg, limbs, chest cavity, etc.). Guidelines for appropriate use include

- ▶ Modifier 50 can be used when the service involves bilateral body organs, such as the kidneys, ureters, and hands.
- ▶ Do not append modifier 50 to procedures on the skin because the skin is one organ.
- ▶ Modifier 50 is not necessary when the CPT code description already states the procedure is bilateral.
- ▶ Do not use modifier 50 when the term "one or both" appears in the CPT code description for the service.
- ▶ Some procedures are considered "inherently bilateral," which means the code descriptor or procedure specifically includes bilateral body parts (see the section on Bronchoscopy). Application of the 50 modifier is therefore not indicated.

Different carriers require different reporting of bilateral procedures and offer different reimbursement structures. Each payer's policy or physicians' contracts should be reviewed for instructions on applying modifier 50 properly on claims forms.

Medicare will pay a unilateral procedure performed bilaterally at 150% of the allowed amount, subject to the patient's deductible and coinsurance. The bill should be increased accordingly when the claim is submitted; Medicare will not increase this amount on its own. As an example, if the allowed amount for the procedure \$100, the coder should increase the billed amount to \$150 on the claim form.

51 Modifier

This modifier indicates that the same provider performed multiple procedures—other than E/M services—at the same session. The most resource-intensive (highest paying) procedure should be listed first, and append modifier 51 to the second and subsequent procedures.

Use modifier 51 to indicate

- ▶ Same procedure, different sites
- ▶ Multiple operation(s), same operative session
- ▶ Procedure performed multiple times

Most payers apply a "multiple procedure discount" with modifier 51. This refers to the practice of reducing the reimbursement for subsequent procedures because of shared resources when two or more procedures are performed together. CPT Appendix E lists codes that are exempt from modifier 51.

The following is an example of multiple operations in the same operative session:

The patient presents for removal of a 0.5 cm malignant skin lesion on the trunk. A layered closure of the resulting wound

is performed in the same operative session. The appropriate coding is

12031 *Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less [typically 100% allowed reimbursement*]*

11600–51 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.5 cm or less [typically reduced reimbursement*]*

*Dependent on carrier policy.

52 Modifier

This modifier should be used when, under certain circumstances, a service is partially reduced or eliminated at the physician's discretion.

Modifier 52 is appended to surgical or diagnostic CPT codes in order to indicate *reduced or eliminated services*. This should be applied only to diagnostic or surgical services that were *reduced* by the provider *by choice*.

Circumstances for applying modifier 52 would *not* include a change to the procedure that was unexpected by the provider.

Modifier 52 should not be applied when

- ▶ The code description includes *unilateral or bilateral*.
- ▶ An existing CPT code properly identifies the reduced service.
- ▶ Anesthesia administration and/or the patient's well-being at risk were factors in ending the procedure.

53 Modifier

This modifier is intended for use on CPT codes in order to indicate discontinued services. This means it should be applied to CPTs which represent diagnostic procedures or surgical services that were *discontinued (not reduced)* by the provider. Most often, the discontinuation of the procedure is due to unforeseen extenuating circumstances that could threaten the well-being of the patient if the service were to be performed or continued.

Many surgeons either forget modifier 53 or simply never learn how to appropriately use it. This may, in part, be due to the fact there is no set definition for "extenuating circumstances," leaving it open to interpretation and diminishing appropriate use. By not using it, surgeons miss out on partial payment for the work that *was* done. Using modifier 53 when the procedure is discontinued also ensures the chance for the provider to fully bill that same procedure later, when it can be performed in its entirety.

The qualifying discontinued service codes for modifier 53 are very specific. CPT Appendix A states, "... due to extenuating circumstances or those that threaten the wellbeing of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding the modifier '53' to the code reported by the physician for the discontinued procedure." Circumstances for applying modifier 53 would *not* include a change to the procedure that was planned or expected by the provider. Therefore, documentation of details is paramount. Also of note is that 53 should be used after surgical prep and/or anesthesia is administered, implying discontinuation, which indicates a procedure was started in the first place.

The surgeon cannot use modifier 53 if the procedure has been discontinued prior to general anesthesia being administered to the patient. In addition, the surgeon cannot use modifier 53 if a procedure that is being performed under local anesthesia has been discontinued, even if it is for the patient's well-being, for example, because the patient is experiencing more pain than they can bear under a local.

Modifier 53 would not apply for

- ▶ Elective cancellation of a procedure
- ▶ Discontinued surgeries prior to anesthesia or surgical prep
- ▶ Evaluation and management (E/M) CPTs
- ▶ Time-based codes (such as for critical care)

Payers are likely to request supporting documentation when modifier 53 is attached to claims. Detailed documentation will help secure appropriate payment for the work done. The following documentation should be included:

- ▶ Each step of the procedure that was able to complete
- ▶ The percentage of the procedure that was performed (for example, 35% complete)
- ▶ Explanation of why it was not possible to proceed with the procedure

Having this documentation complete and readily available for payer review can help facilitate timely reimbursement.

NOTE: Modifier 53 for *discontinued services* is somewhat similar to modifier 52 for *reduced services*, but note these two are distinctly different as far as how they should be correctly used. These modifiers can be confusing, and applying them incorrectly can lead to underpayment or denials.

Choosing between modifier 53 and modifier 52 is all dependent on the physician's reason for stopping the procedure. If appending modifier 52 to a claim, maintain documentation explaining why the procedure was curtailed. The documentation should provide extensive detail to allow the payer to make a reimbursement decision.

57 Modifier

This modifier may be used to indicate that an evaluation and management (E/M) service performed on the same day or the day before a major surgery (90-day global period) by the surgeon resulted in the decision to perform the procedure. As always, documentation in the patient's medical record must support the use of this modifier. This modifier may only be submitted with E/M codes. This modifier should *not* be submitted with E/M codes that are explicitly for *new patients* only. New patient codes are automatically excluded from the global surgery package. This means that they are reimbursed separately from surgical procedures. E/M services on the same day as a procedure with 0 or 10 global days are generally not payable separately from the procedure. For additional information, please refer to CPT modifier 25. No supporting documentation is required with the claim when this modifier is submitted.

A surgeon should always be paid for an E/M service that is the initial evaluation prior to a major surgery. However, if the E/M service occurs days or weeks before a scheduled surgery, no modifier is needed on the E/M service. If a surgeon is called to see a patient urgently and decides to take the patient to surgery that day or the next day (calendar day, not 24-hour period), modifier -57 should be appended to the E/M service. The E/M service could be an office visit, ED visit, or initial hospital service—any category of service.

Use of modifier 57 versus 25

- ▶ Use modifier 25 on an E/M service provided on the same day as a minor procedure. Remember, the NCCI edits require that the E/M is separate and distinct, that the physician or non-physician practitioner (NPP) needed to evaluate a condition prior to the decision to perform the procedure. Payment for the decision to perform the procedure is included in the payment for the procedure. But, often, a physician is called to evaluate a condition, and performs a separate and distinct

E/M service. On the same day, a procedure is performed. For example, a physician is called to evaluate a patient with anemia and bleeding, and performs an endoscopy that day. Endoscopy has 0 global days. Report both the E/M and the endoscopy using a 25 modifier.

- ▶ Append modifier 57 to any E/M service on the day of or the day before a *major* surgical procedure when the E/M service results in the decision to go to surgery.
- ▶ Appeal denials up to the Medical Director of the plan. A surgeon should always be paid for the E/M prior to an urgent/emergency surgery.
- ▶ Do not append modifier 57 on the E/M for the decision for surgery if the surgery is scheduled later than the day after the E/M service.

Some private payers and some managed Medicaid companies do not recognize modifier 57. Providers of the service should appeal each denial to in order to obtain payment of the claim. These efforts are sometimes successful and sometimes, unfortunately they are not.

If denials are occurring and appeals rejected, some recourses include contacting your professional association (ACS, AAST, AAOS, etc.) to seek advice and support, write to your insurance commissioner to report that the payer is not following CPT and CMS rules, and contact the plan medical director directly to discuss the matter.

58 Modifier

Modifier 58 is defined by CPT as “staged or related procedure or service by the same physician during the post-operative period.” It may be necessary to indicate that the performance of a procedure or service during the postoperative period was (1) planned or anticipated (staged), (2) more extensive than the original procedure, or (3) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure.

This modifier has multiple uses. Some believe that the physician has to specifically state the planned stages in order for a procedure to qualify for the 58 modifier. This is not the case. The subsequent procedure can be within a stated plan of care, or it can be implied, executing a more extensive procedure because the original procedure did not achieve the desired outcome as planned.

This modifier starts a new global period of the duration assigned to the related procedure being performed.

59 Modifier

This modifier is used to indicate a distinct procedural service and describes a different session or encounter, a different procedure, a different site or a separate incision, excision, lesion, injury or body part.

Modifier 59 is frequently appended to those codes defined as “separate procedures” in the CPT set. Designated separate procedures commonly are carried out as an integral component of a more extensive procedure. Only when a procedure or service designated as a separate procedure is carried out independently, and is considered to be unrelated or distinct, may it be reported separately.

NOTE: Modifier 59 versus Modifier 51—According to CPT rules, when multiple procedures are performed at the same session by the same provider, you may identify the additional procedure(s) or service(s) by appending modifier 51. CPT, however, also describes the use of modifier 59 to denote two procedures or services that are not usually submitted together,

but are appropriate under the circumstances. CPT further instructs that modifier 59 is not to be used if another already established modifier is appropriate. Therefore, modifier 59 is sometimes referred to as “The modifier of last resort.”

When choosing between modifiers 51 and 59, payer policy may be the determining factor. Some payers, including Medicare contractors, do not acknowledge modifier 51. While code selection should not be based solely on reimbursement, be cognizant that modifier 51 may trigger the multiple payment reduction. On the other hand, modifier 59 may trigger a front-end edit, and the payer may require documentation, which will delay claim reimbursement.

A good reference are the National Correct Coding Initiative (NCCI) edits, which provide directions on when to appropriately “unbundle” procedure codes. NCCI edits are valid for Medicare only, but other payers are permitted to follow these guidelines. NCCI resources can be found on the CMS website.

62 Modifier

This modifier applies to co-surgery and indicates that two surgeons were working together as primary surgeons performing distinct parts of a single reportable surgical procedure. Each surgeon should report the distinct work that they did by adding the modifier 62 to the single distinct procedure code. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedures) are performed during the same surgical session, separate codes may be reported without adding the 62 modifier. If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s), with modifier 80.

76 Modifier

This modifier is defined as a repeat procedure by the same physician on the same date of service or patient session. The CPT defines “same physician” as not only the physician doing the procedure but also as a physician of the same specialty working for the same medical group/employer.

77 Modifier

This modifier is defined as a repeat procedure by another physician on the same date of service or patient session. “Another physician” refers to a physician in a different specialty or one who works for a different group/employer. Medical necessity for repeating the procedure must be documented in the medical record in addition to the use of the modifier.

78 Modifier

Modifier 78 is defined as an “unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the post-operative period. When this procedure is related to the first and requires the use of an operating room or procedure room, it may be reported by adding modifier 78 to the related procedure.” This represents provision of this service as a result of the original surgery, not the original condition. It does not generate a new global period.

Two requirements of this modifier are

1. The patient must be returned to the O.R. or endoscopy suite to qualify for the 78 modifier. Unlike modifiers 58 and 79, 78 *may not be performed anywhere but in the O.R. or the endoscopy suite.*

2. The reason for the subsequent surgery is related to the original surgery, meaning that there is a complication of the surgery requiring a return to the O.R. or endoscopy suite.

79 Modifier

Modifier 79 is defined by CPT as “*unrelated procedure or service by the same physician during the post-operative period.*” It is used in the strictest sense for care that is entirely unrelated to the prior surgery that created the current global period. In fact, it initiates a new global period based on the unrelated procedure.

For example, a patient who is in the postoperative period for arthroscopic shoulder surgery may fall and fracture their leg. Care of their leg is unrelated to the global period created by the shoulder surgery and therefore, any procedure for the leg would have a 79 modifier appended. Services that qualify for a 79 modifier may be performed anywhere.

NOTE: Modifiers 58, 78, and 79 are all used in conjunction with procedures performed within the global period of another procedure. There is sometimes confusion over discerning when to use a 58 modifier versus a 78 modifier. One method to differentiate is to differentiate the reason for the additional procedure in the global period. If it is due to the *original condition* which created the global period, then the appropriate coding involves use of the 58 modifier. However, if the reason for the new procedure is due to a *prior procedure* and not the original condition, that is, a complication of the original procedure such as a post-operative wound infection or a postoperative hemorrhage, the 78 modifier is more appropriate.

80, 81, 82 Modifiers

These denote an assistant surgeon. These should be submitted on those surgical procedures where an assistant surgeon is warranted. It should be noted that physicians acting as assistants cannot bill as co-surgeons.

Modifier 80 is appended to the surgical code when another surgeon is assisting at surgery. This allows 16% of the customary full surgery fee schedule to be reimbursed. Non-Physician Practitioner (NPP) or mid-level practitioner (PA, NP, CNS) cannot apply this modifier but should use the AS modifier instead.

Modifier 81 is appended to the procedure code for an assistant surgeon who assists an operating or principal surgeon during part of a procedure. This pertains only to physicians providing minimal assistance to primary surgeon.

Modifier 82 should be utilized when minimal surgical assistance is needed, but a qualified resident was unavailable. This circumstance should be documented in the Operative Note or elsewhere in the EMR.

For additional information on Modifiers, see the following resources:

- ▶ <https://med.noridianmedicare.com/web/jeb/topics/modifiers> (accessed May 18, 2020)
- ▶ www.medicalbillingcptmodifiers.com/p/list-of-cpt-hcpcs-modifiers.html (accessed May 18, 2020)
- ▶ www.medicalbillingcptmodifiers.com/2010/08/surgical-procedure-modifiers.html (accessed May 18, 2020)
- ▶ <https://www.cms.gov/Medicare/Coding/NationalCorrectCodingInitEd> (accessed May 25, 2020)
- ▶ <https://codingintel.com/billing-guide-cpt-hcpcs-code-modifiers/> (accessed May 25, 2020)
- ▶ www.medicalbillingcodings.org/2016/04/cpt-modifier-52-or-53-and-medicare.html#:~:text=CPT%20Modifier%2052.%20Modifier%2052%20is%20usually%20used,can%20be%20several%20reasons%20behind%20the%20

20physician%E2%80%99s%20decision (accessed Jul 1, 2020)

- ▶ <https://www.physicianspractice.com/understanding-modifiers-58-78-79>

Telemedicine/Telehealth Encounters

Telemedicine and virtual encounters, particularly for E/M services, are increasingly prevalent. Telemedicine, also known as telehealth, is viewed as a cost-effective alternative to traditional face-to-face encounters and may eventually supplant the conventional personal interactions. Therefore, surgeons and their coders need to be familiar with these E/M codes and the documentation to justify and maximize reimbursement for these claims. These are, for the most part, uncharted waters with rules governing claims and payments being different for different payers and frequently changing between the payers and within an individual payer. Therefore, vigilance regarding these changes is necessary to avoid denials, appeals and resubmission of claims.

The Centers for Medicare & Medicaid Services (CMS) have set Medicare payment criteria for these services. Some commercial and managed care payers have also set payment guidelines for telemedicine services.

CMS has established the following criteria for Medicare patients.

Patient must be at a qualifying location

The patient must be present at a qualified originating site. A site is considered “qualified” if it meets two criteria. First, the originating site must be physically located in either

- ▶ A rural health professional shortage area (HPSA) located either outside of a metropolitan statistical area (MSA) or in a rural census tract, or
- ▶ A county outside of an MSA.

Second, the patient must be at one of the following places of service:

- ▶ The office of a physician or practitioner
- ▶ Hospital
- ▶ Critical access hospital (CAH)
- ▶ Rural health clinic
- ▶ Federally qualified health center
- ▶ Hospital-based or CAH-based renal dialysis center, including satellites
- ▶ Skilled nursing facility
- ▶ Community mental health center

Practitioner must be qualified to receive payment

Practitioners at the distant site who may provide telehealth services and receive payment for them include Physicians, Nurse Practitioners, PAs, Clinical Nurse Specialists and others.

Use Modifiers GT and GY, as appropriate

In the past, when billing for telehealth services provided from an eligible originating site, appending a modifier, GT (*Via interactive audio and video telecommunications system*), to the CPT or HCPCS Level II code was required to indicate that the service described was provided as a telehealth service. However, Modifier GT is no longer required on professional claims when reporting telehealth services for Medicare patients. Instead, CMS rules now state, “Use of the telehealth Place of Service (POS) Code 02 certifies that the service meets the telehealth requirements.”

An exception occurs for distant site services billed under Critical Access Hospital (CAH) method II on institutional claims. In these cases, modifier GT will still be required.

Further confusing the issue is that the American Medical Association created a new telehealth modifier in 2017, Modifier 95 (*Synchronous telemedicine service*), but Medicare does not recognize this modifier. Medicaid requires GT Modifier and POS 02. A 95 modifier is applied to CPT codes 99201–99215, 99212–99215 visits for Medicare without POS 02. Medicare does not require POS 02 or 95 modifier on phone E/M services. When billing payers other than Medicare for telehealth, the specific payer guidelines should be reviewed to determine the correct modifier use.

If a telehealth service is provided for a Medicare patient located at an ineligible originating site, consider appending Modifier GY (*Item or service statutorily excluded, does not meet the definition of any Medicare benefit or for non-Medicare insurers, is not a contract benefit*). Appending this modifier will allow tracking of telehealth services provided while indicating the payer’s reimbursement criteria have not been met.

Telehealth visits can be billed according to medical decision making or time, so if the code indicates it can be a time-based service, then the service can be billed accordingly.

Telephone E/M service are the following:

- 99441—5–10 min
- 99442—11–20 min
- 99443—21–30 min

Medicare HCPCS Code G2012—A brief communication (5–10 min), a virtual check in with your practitioner via telephone or other telecommunication device.

- Office or other E/M codes for telemedicine encounters include
- 99201–99205, New patient visit.
- 99212–99215, Established patient visit.
- 99241–99245, Consultative visit

CPT codes for online digital visits (E-visits) via patient portal, secure email are

- 99421 (5–10 min)
- 99422 (11–20 min)
- 99423 (21 or more minutes)

Medicare accepted telehealth codes

Medicare provides a list of CPT and HCPCS Level II codes eligible for reimbursement when provided via telehealth on its website (www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html).

Individuals can submit a request to CMS for an addition to the approved list, but their submission must meet the CMS criteria to be considered (see www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Criteria.html). Not all payers cover telehealth services.

Documentation requirements

Providers should be aware that documentation requirements for a telehealth service are the same as that required for any face-to-face patient encounter, with the addition of the following:

- ▶ A statement that the service was provided using telemedicine and type of telehealth service (visual and audio, audio only or E-visits);
- ▶ The location of the patient;
- ▶ The location of the provider; and
- ▶ The names of all persons participating in the telemedicine service and their role in the encounter.
- ▶ Patient consent for telehealth visit

See the following resources for more information on Telehealth encounters:

- ▶ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsh.pdf> (accessed May 18, 2020)
- ▶ <https://healthcare.trainingleader.com/2020/03/telehealth-cms-billing-modifier-pos/> (accessed May 18, 2020)
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- ▶ <https://www.outsourcestrategies.com/blog/billing-coding-telemedicine-services-key-considerations.html> (accessed June 10, 2020)

Robotic Surgery

Robotic surgery is covered by routine and customary laparoscopic CPT and ICD-10-CM coding practices, existing medical policies for advanced laparoscopic surgery, and current payer

contract rates. The primary surgical procedure remains laparoscopic: a surgeon should not report unlisted procedure codes or modifier 22 *Increased procedural services* for robotic assistance (except perhaps, for instance, there is no existing laparoscopic code to describe a procedure).

Although any insurance covering minimally invasive surgery (including Medicare) generally covers robotic surgery, no additional payment is made when a robotic surgical technique is used.

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