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Provider update

Modifier use reminders

Billing for patient treatment can be complex, particularly when determining whether modifiers are required for proper payment. Amerigroup Community Care reimbursement policies and correct coding guidelines explain the appropriate use of coding modifiers. We would like to highlight the appropriate use of some commonly used modifiers.

Things to remember

- Review the *CPT® Surgical Package Definition* found in the current year's *CPT Professional Edition*. Use modifiers such as 25 and 59 only when the services are not included in the surgical package.
- Review the current *CPT Professional Edition Appendix A — Modifiers* for the appropriate use of modifiers 25, 57 and 59.
- When an evaluation and management (E&M) code is reported on the same date of service as a procedure, the use of the modifier 25 should be limited to situations where the E&M service is "above and beyond" or "separate and significant" from any procedures performed the same day.
- When appropriate, assign anatomical modifiers (Level II HCPCS modifiers) to identify different areas of the body that were treated. Proper application of the anatomical modifiers helps ensure the highest level of specificity on the claim and show that different anatomic sites received treatment.
- Use modifier 59 to indicate that a procedure or service was distinct or independent of other non-E&M services performed on the same date of service. The modifier 59 represents services **not normally** performed together, but which may be reported together under the circumstances.

If you feel that you have received a denial after appropriately applying a modifier under correct coding guidelines, please follow the normal claims dispute process and include medical records that support the use of the modifier(s) when submitting claims for consideration.

Amerigroup will publish additional articles on correct coding in provider communications.