Mastering Modifiers, Part 2: Continuing the CodeFest Quiz

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When the audience at AAO 2015's CodeFest was quizzed on coding, many attendees had trouble answering the questions on modifiers—7 of which were published in last month's Savvy Coder, and 7 more appear below. Of those 14 questions, only 4 were answered correctly by more than half of the participants. Can you do better?

Test Your Knowledge

Q8. Punctal dilation and irrigation did not resolve the excessive tearing problem of a patient's right lower lid. Within the gobal period, a balloon catheter is inserted. In addition to –RT, what modifier should you append to the catheter insertion code? **A.** –58; **B.** –78; **C.** –79; or **D.** No modifier is needed. *(At CodeFest, only 34.5% of respondents answered correctly.)*

Q9. You perform a test on a Medicare Part B patient. You are in a location designated as a Health Professional Shortage Area (HPSA). If your ZIP code doesn't automatically qualify you for the HPSA bonus, modifier –AQ should be appended to: **A.** The exam code; **B.** The technical component (–TC) of the test; **C.** The professional component (–26) of the test; or **D.** All of the above. *(Answered correctly by 23.7%.)*

Q10. A Medicare Part B patient receives an injection in the left eye for an off-label, noncovered diagnosis. Correct claim submission for the injection and the specific drug should be: **A.** 67028–GA–LT and JXXXX–GA–LT; or **B.** 67028–GY–LT and JXXXX–GY–LT. *(Answered correctly by 57.7%.)*

Q11. During the global period of a vitrectomy in the left eye (CPT code 67036), an unplanned paracentesis of the anterior chamber was performed (CPT code 65800) on the same eye in the office's dedicated procedure room. In addition to modifier –LT, you should append: **A.** –58; **B.** –78; **C.** –79; or **D.** Don't bill! Because the paracentesis was not performed in an ASC, it is part of the postop package and is not separately billable. *(Answered correctly by 36.5%.)*

Q12. An iridotomy/iridectomy by laser surgery is performed in the right eye. The patient returns in 2 weeks for a peripheral iridotomy in the left eye (CPT code 66761). You should append: **A.** –LT only; **B.** –78 –LT; or **C.** –79–LT. *(Answered correctly by 27.8%.)*

Q13. During cataract surgery in a patient's right eye, complications arose, and an IOL was not inserted until 1 month later. You submit CPT code 66850 for the first procedure—what should you submit for the second? **A.** 66985–58–RT; or **B.** 66985–78–RT. *(Optimal answer was given by 46.5%.)*

Q14. You see a patient who had surgery at another physician's practice less than 1 week ago. The patient is experiencing complications from his surgery and came to see you because the other practice is much further away. How should you bill this encounter? **A.** Surgical code with modifier –55; **B.** Appropriate level of E&M or Eye visit code appended with modifier –24; or **C.** Appropriate level of E&M or Eye visit code without a modifier. *(Answered correctly by 83.1%.)*

Answers **8.** A –58. Modifier –58 is used when a second procedure is more extensive than the original procedure. **9.** C –26. CMS sends a quarterly check for HPSA bonuses. **10.** B –GY–LT; if you submit the claim at all. When not covered, the patient is responsible for the drug and the injection. To see the payment policies for all injectable drugs, go to www.aao.org/coding and click "help with proper coding of injectable drugs." **11.** B –78. **12.** A –LT only, because the surgical code has a 10-day global period. **13.** A 66985–58–RT is the optimal answer. If the second procedure was not a planned procedure at the time of the cataract removal, then 66985–78–RT is also acceptable. However, –58 allows the full fee schedule, and a new global period begins; modifier –78 reduces the allowable by 20%, and the original global period continues. **14.** C E&M or Eye visit code without a modifier. There was no prearranged transfer of postoperative care.