

MEDICAL INSIDER™

A Newsletter for Physicians Using HMA Facilities

Volume 4 Issue 3

March 2010

CPT MODIFIERS

CPT codes are hard enough—but consider knowing about CPT modifiers. CPT modifiers are a useful tool: the two digits you can add to the CPT Code to make them more expressive. You should look at these modifiers as what adverbs are to novelists. Keep a short list of modifiers handy with your coding cheat sheets. Often the office staff will not have access to the history taken in the ER or Hospital Room, so the physician should use the code modifiers to indicate the nuances of care.

- Adding 22 (unusual procedures services) is an intensifier and 52 (reduced services) is when the best code in the CPT overstates the service. Review the other modifiers.
- Three (21, 24 and 25) are very important when using the E&M Codes
- And don't forget the HCFA additions to the CPT System.

Finally there are some codes you shouldn't use unless you absolutely must. They make it easy to reject or modify your claim, and that always costs physicians money. Resist using unlisted procedure codes (usually ending in 99).

Remember, it may be reasonable to have one physician in the practice attend a coding course on an annual basis, and have that physician share his/her knowledge with the remaining physicians. Again, this is the language you need to learn to speak in order to get paid.

PRACTICE GUIDELINES BASED ON EVIDENCE-BASED MEDICINE

Practice guidelines based on evidence-based medicine are increasingly being utilized, and they are beneficial in the sense that they help physicians practice in ways consistent with the best aggregate knowledge and expert opinion. Several sources for guidelines exist. The Agency for Healthcare Research and Quality (AHRQ) systematically reviews and vets guidelines submitted for inclusion in the National Guideline Clearing house (www.guideline.gov) and makes them available for evidence-based clinical decision making. The table below shows a common outline used for applying classification of recommendations and level of evidence.

Applying Classification of Recommendations and Level of Evidence				
SIZE OF TREATMENT EFFECT →				
	CLASS I <i>Benefit >>> Risk</i> Procedures/Treatment SHOULD be performed/ administered	CLASS IIa <i>Benefit >> Risk</i> <i>Additional studies with focused objectives needed</i> IT IS REASONABLE to perform procedure/administer treatment	CLASS IIb <i>Benefit > Risk</i> <i>Additional studies with broad objectives needed; additional registry data would be helpful</i> Procedures/Treatment MAY BE CONSIDERED	CLASS III <i>Benefit > Risk</i> Procedures/Treatment should NOT be performed/administered SINCE IT IS NOT HELPFUL AND MAY BE ARMFUL
ESTIMATE OF CERTAINTY (PRECISION) OF TREATMENT EFFECT	LEVEL A Multiple populations revaluated*	<ul style="list-style-type: none"> ▪ Recommendation that procedure or treatment is useful/effective ▪ Sufficient evidence from multiple randomized trials or meta-analyses 	<ul style="list-style-type: none"> ▪ Recommendation in favor of treatment or procedure being useful/effective ▪ Some conflicting evidence from multiple randomized trials or meta-analyses 	<ul style="list-style-type: none"> ▪ Recommendation's usefulness/efficacy less well established ▪ Greater conflicting evidence from multiple randomized trials or meta-analyses
	LEVEL B Limited populations evaluated*	<ul style="list-style-type: none"> ▪ Recommendation that procedure or treatment is useful/effective ▪ Evidence from single randomized trials or nonrandomized studies 	<ul style="list-style-type: none"> ▪ Recommendation in favor of treatment or procedure being useful/effective ▪ Some conflicting evidence from single randomized trials or nonrandomized studies 	<ul style="list-style-type: none"> ▪ Recommendation that procedure or treatment is not useful/ effective and may be harmful ▪ Evidence from single randomized trials or nonrandomized studies
	LEVEL C Very limited evaluated*	<ul style="list-style-type: none"> ▪ Recommendation that procedure or treatment is useful/effective ▪ Only expert opinion, case studies, or standard of care 	<ul style="list-style-type: none"> ▪ Recommendation in favor of treatment or procedure being useful/effective ▪ Some conflicting evidence from multiple randomized trials or meta-analyses 	<ul style="list-style-type: none"> ▪ Recommendation's usefulness/efficacy less well established ▪ Only diverging expert opinion case studies, or standard of care
Suggested phrases for writing recommendations	Should; is recommended is indicated is useful/effective /beneficial	Is reasonable Can be useful/effective/ Beneficial is probably Recommended or indicated	May/might be considered may/ might be reasonable usefulness/ effectiveness is unknown/ uncertain or not well-established	is not recommended; is not indicated; should not; is not useful/effective/beneficial may be harmful

*Data available from clinical trials or registries about the usefulness/efficacy in different subpopulations, such as gender, age, history of diabetes, history of prior myocardial infarction, history of heart failure, and prior aspirin use

Source: *Prevention of venous thromboembolism: American College of Chest Physicians Evidence-based Clinical Practice Guidelines, 85th ed. Chest. 2008; 133 (6 suppl):381S-453S*



LET US KNOW: Please feel free to write us with your observations, suggestions or thoughts at Ron.Riner@hma.com or rriner@rinergroup.com.— Ronald N. Riner, MD, Chief Medical Officer