Eli's Rehab Report

Modifiers: Clear Up Modifier Confusion

Tip: Watch for CCI edits in case of denials.

Are you over-using modifiers? Make certain you know when to report them and when to avoid them to keep your claims in the clear.

"Medicare is rejecting 97003 and 97004. I've used the modifiers GO/GP and even tried 59. They are being rejected no matter what I do. Please help! ... I saw on Medicare that you are supposed to use GO for OT and GP for PT. Did those change?" asks a Codify Subscriber.

Keep Track Of The Code Being Used

Codes 97003 and 97004 are meant for evaluation and reevaluation by an occupational therapist. So, using modifier GP which is specifically meant for physical therapists is out of the question for an OT claim. Using modifier 59 – Distinct Procedural Service – makes even less sense since it is meant to tip off the payer that certain performed services are not normally done together, but an exception is appropriate in a particular case. Modifier 59 refers to a separate procedure for a separate site or separate encounter. You can't append modifier 59 just to get your claim paid – you have to actually be able to justify using it.

Warning: Overusing the 59 modifier can indicate to insurers that you routinely unbundle services, and they can initiate a review based on this suspicion. Your documentation must clearly identify the medical necessity and separate nature of the unbundled service. Remember that the need for modifier 59 is provider-specific, not discipline-specific.

Been There, Seen That

Many therapy practices have gotten caught in the same trap when billing Part B therapy services: incorrectly using Modifier 59 on claims that either don't represent a distinct service or lack enough documentation to support the services performed.

GO is used as a therapy modifier only for Therapy Functional Reporting, not for reevaluation. Plus, the KX and 59 modifiers are not applicable to the line of service for the functional G-codes. If you are using these codes for functional reporting, keep in mind that G codes are the non-paying codes. To get paid for re-evals, there should be a proper plan of care (POC) in place and the re-eval should mark progress.

Most important: If you use any modifier for the 97003 and 97004 codes, they will be denied. The CCI edits of 2012 list 97004 as, OT Re-Eval, N, 97003n, where N stands for no modifier is required. If 97004 is billed with 97003, only 97004 is payable.

The CMS guidance is: Use the CH modifier to reflect a zero percent impairment when the therapy services being furnished are not intended to treat a functional limitation.

Key: Keep the following condition of coverage and payment in mind, CMS says:

The beneficiary functional limitations(s) reported on claims, as part of the functional reporting, must be consistent with the functional limitations identified as part of the therapy plan of care and expressed as part of the beneficiary's anticipated long term goals.

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