April 14, 2011

Dear Physician or other Health Care Practitioner:

Univera Healthcare would like you to be aware of two new modifiers created to aid compliance with health care reform law (Patient Protection and Affordable Care Act or PPACA) — **modifier 33 and modifier PT**.

Modifiers 33 and PT became effective on January 1, 2011. Univera Healthcare is currently updating its claims processing systems to accept these modifiers and we will notify you once this update is complete.

Claims submitted with these modifiers will be processed according to PPACA guidelines. If you have received a claim that you believe was processed in error, please contact Provider Service for an adjustment.

Billing Guidelines

Modifiers 33 and PT are key components to submitting accurate preventive services claims; as such, it's important to review and become familiar with the following billing guidance.

Modifier 33 ➢ The appropriate use of modifier 33 will help reduce claim adjustments related to preventive services and your corresponding refunds to members. Modifier 33 applies to commercial lines of business only.

- CPT modifier 33 is applicable to preventive services that do not have a unique code for such services (e.g., E&M codes such as, 99401 **would not require** modifier 33 as this code already indicates a preventive medicine service. However, code 99213 **would require** modifier 33 when the provider indicates that the service was preventive).
- If multiple preventive medicine services are provided on the same day, then the modifier is appended to the codes for each preventive service rendered on that day.
- Modifier 33 should be used when only preventive services were rendered on that date, not when combined with other non preventive services.
- CPT codes not appended with modifier 33 will process under the member's medical or preventive benefits, based on the diagnosis and CPT codes submitted.
- CPT codes identified as inherently preventive (e.g., screening mammography) should not be appended with modifier 33.
- This modifier may be used to identify when a service was initiated as a preventive service, which then resulted in a conversion to a therapeutic service. The most notable example of this is screening colonoscopy (code 45378), which results in a polypectomy (code 45383).

Additional information about modifier 33 is available via the American Medical Association website, http://www.ama-assn.org/ama1/pub/upload/mm/362/new-cpt-modifier-for-preventive-services.pdf.

Modifier PT ➢ Modifier PT applies to Medicare products only (Medicare Advantage and Medicare Supplemental). To determine the appropriate use of modifier PT, it's important to know why the member is presenting for treatment.

Modifier PT indicates that a colorectal cancer screening test was converted to a diagnostic test or other procedure (impacts colonoscopy and sigmoidoscopy codes). The appropriate use of modifier PT will help reduce claim adjustments related to colorectal screenings and your corresponding refunds to members.

Please see the following scenarios for guidance:

➢ **Screening exam only:** In a situation where a member presents for treatment solely for the purpose of a screening exam, without any signs or symptoms of a disease, then such a procedure should be considered a screening. The appropriate use of diagnosis codes and screening procedure codes is valuable in promoting appropriate adjudication of the claim. The use of the modifier PT in conjunction with a CPT procedure or HCPCS code that is defined as a screening based on that code's description is not necessary.

➢ **Treatment due to signs or symptoms to rule out or confirm a suspected diagnosis:** In the instance that a member presents for treatment due to signs or symptoms to rule out or confirm a suspected diagnosis, such an encounter should be considered a diagnostic exam, not a screening exam. In such a situation, the modifier PT should not be used and the sign or symptom should be used to explain the reason for the test.

➢ **Screening colorectal exam converted to a diagnostic service:** In a circumstance where a member presents for a screening exam (without signs or symptoms), and an issue is encountered during that preventive exam, then such a circumstance would warrant the use of the PT modifier. The procedure and diagnosis codes that would typically be used in such an instance may not clearly demonstrate that the service began as a screening procedure, but had to be converted to a diagnostic procedure due to a pathologic finding (e.g., polyp, tumor, bleeding) encountered during that preventive exam. The use of the PT modifier in the instance of a screening colorectal exam being converted to a diagnostic service would clarify that despite the end result the service began as a screening service.

Additional information about modifier PT is available via the Centers for Medicare & Medicaid Services website, www.cms.gov/MLNMattersArticles/downloads/MM7012.pdf.

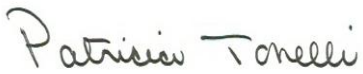
Preventive Services Grid

To access the most current version of the Preventive Services Grid, which outlines the mandated preventive services and indicates codes for which modifier 33 is required,* visit the Health Care Reform section of our website, univerahealthcare.com/healthreform.

If you do not have Internet access, contact Provider Service to obtain a paper copy of the grid.

We hope that you find this information helpful as you conduct business with our organization.

Sincerely,



Patricia Tonelli
Regional Manager
Provider Relations

*The Preventive Services Grid does not apply to Medicaid, Child Health Plus, Family Health Plus, Medicare Advantage, Medicare Supplemental and Medicare Part D.