Coding Rules for Modifier 33 and Modifier PT

At A Glance

- Modifier PT is a level II modifier used to indicate a colorectal screening service converted to a diagnostic or therapeutic service, ensuring patients aren't charged co-pays or deductibles.
- Modifier 33 is a CPT modifier that denotes covered preventive services following USPSTF guidelines, requiring payers to reimburse these services without patient costs.
- While modifier PT is specific to colorectal screenings converted to diagnostic or therapeutic services, modifier 33 broadly applies to any ACA-designated preventive service with a commercial payer.

It can be difficult to keep track of all the different coding rules when it comes to researching modifiers. Physicians and practices who conduct colorectal screening services for patients may find themselves coming across "modifier PT" for billing. This blog will walk through modifier PT, as well as modifier 33, so that practices have a deeper understanding of how they affect medical claims processing for this specific service.

Level I and level II Modifiers Explained

Modifiers do one of 2 things. They either provide additional information regarding the service provided, such LT and RT, left and right, or they affect payment. The modifiers that affect payment either allow payment at all, such as modifier 33, or they affect the amount of payment above or below the usual rate.

Modifiers are created by both the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA). Level I modifiers are CPT modifiers, like CPT codes. These modifiers are always 2 numbers. Modifier 33 then is a level I, or CPT modifier.

CMS creates level II modifiers, referred to as HCPCS modifiers, like HCPCS codes. They are either 2 letters or a letter and a number. Modifier PT is a level II, or HCPCS modifier.

What is Modifier PT?

Modifier PT is a level II modifier that indicates that a colorectal screening service was converted to a diagnostic or therapeutic service.

Medicare covers screening colonoscopies without a co-pay or deductible and coinsurance. These screening colonoscopies are billed with HCPCS codes to Medicare (G0105 and G0120).

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A patient who schedules a screening colonoscopy expects that Medicare will pay in full for the procedure.

What if a polyp is discovered?

Previously, this conversion to a therapeutic procedure meant the patient was responsible for a co-pay and deductible and co-insurance.

To prevent the patient from paying a co-pay or deductible and co-insurance, the surgeon should append modifier PT to the CPT code or HCPCS procedure that describes the performed procedure. This alerts the payer that the procedure was scheduled as a screening colonoscopy and should follow those payment policies, regardless of its outcome.

For the diagnosis code, practices should use the condition that supports the CPT code, such as polyp or lesion in the first position and the screening diagnosis in the second position.

What is Modifier 33?

Modifier 33 is a CPT modifier, defined as: “Modifier 33, Preventive Services: When the primary purpose of the service is the delivery of an evidence-based service in accordance with the US Preventive Services Task Force (USPSTF) A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending modifier 33, Preventive Service, to the service.”

AMA developed modifier 33 to denote covered preventive services that fall within the USPSTF guidelines and that the payer must reimburse without cost to the patient.

"Modifier 33 was developed by the AMA to denote covered preventive services that fall within the USPSTF guidelines and must be reimbursed by the payer without cost to the patient."

The USPSTF recommends these preventive and screening services. These recommendations guide medical practices, patients, and payers in determining preventive or screening services for individual patients.

The Affordable Care Act (ACA) requires Medicare to cover services with an A or B rating at 100%, with no co-pay or deductible for fee-for-service Medicare beneficiaries. It also mandates that group health insurance policies that renewed after September 2010 provide first-dollar coverage for the services with an A or B rating from the USPSTF. (Group insurers could apply for a waiver and be grandfathered in.)

Modifier 33 is used to tell the payer to process the service without a patient due balance, because it was a preventive service with an A or B rating from the USPSTF.

Not all commercial patients will have this first-dollar coverage, but many with group health insurance plans will. Also, many medical groups that perform these services check the patient's insurance eligibility and verify benefits before providing the service.
This decreases the likelihood of a denial.

What Services Have a Grade A or B Rating?

The US Preventive Services Task Force website features A list of recommendations with a grade of A or B.

What if the group forgets the modifier?

Insurance companies process claims based on the group benefit plan that is built into their system.

The characteristics of the benefit plan are part of the processing:

- How much is the deductible?
- What is the co-pay for seeing a specialist?
- Does it cover a preventive service?

With or without the modifier, most claims processing systems should pay the claim correctly for these preventive services.

Modifier 33 is a valid CPT modifier and may be used for all payers. Check with individual payers for their instructions.

Should you also append modifier 33, so that the code is 45380 -PT-33?

This would duplicate information. Using PT indicates that a covered screening colonoscopy was converted to a diagnostic. Adding -33 shows that a covered screening colonoscopy was performed. In essence, -PT already includes -33 — it just provides duplicate information (a USPSTF service was provided).

What about commercial insurance companies? Should a medical practice also use modifier PT or just modifier 33?

Commercial payers will vary in how they use PT since it is a Medicare modifier, so follow each payer's policy. Just as with Medicare, a practice should bill each payer according to its payment policies.

When to use modifier 33 and PT

There are many services for which modifier 33 applies, since it is used to bill for any ACA-designated preventative service with a commercial payer. Not all preventative services require modifier 33 though — ones such as preventive medicine 99381-99429 do not require modifier 33 because the nature of the code itself describes a preventive service.

Modifier PT is used only when a colorectal screening converts to a diagnostic or therapeutic service and as such, is more limited in its scope.

The AMA and CMS now work more closely together to create modifiers and codes so that there is less overlap than when these modifiers were first created.