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Pam Joslin, MM, CMC, CMIS, CMOM, CMCO

On the topic:

Modifiers - Tell It Like It Is
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Modifiers – Tell It Like It is

Presented by:
Pam Joslin, MM, CMC, CMIS, CMOM, CMCO
Practice Management Institute®

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Introduction

Over the past decades, physicians have learned that coding and billing are an entwined process.

Coding provides the common language necessary for physicians to communicate and bill their services to the third-party payers, including managed care organizations along with federal state program such as Medicare and Medicaid.

• The use of modifiers is an important part of coding and billing. Over the years, commercial payers along with Medicare and Medicaid have come to recognize and accept modifiers as part of their reimbursement protocol.

• The correct use of modifiers is an important tool in avoiding fraud and abuse in the coding and billing process with federal programs. One of the top 10 billing errors determined by federal, state, and private payers involves the incorrect use of modifiers.
A modifier is a two-digit numeric or alphanumeric character reported with a HCPCS (Healthcare Common Procedure Coding System) code.

Modifiers are designed to give additional information needed to the commercial and federal payers to process a claim.

- A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.
- Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities.
Appropriate Use of a Modifier

- A service or procedure has both a professional and technical component, but both components are not applicable in this case.
- A service or procedure was performed by more than one physician.
- A service or procedure has been increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- A service or procedure was performed more than once.
- Unusual events have occurred.

So, Where Are These Modifiers?

- Two-digit numerical modifiers that are valid to use with CPT codes are listed in the CPT manual in Appendix A located at the back of the CPT manual.
- This appendix includes modifiers valid for use with CPT codes for ambulatory surgery centers (ASC) and outpatient hospital departments.
- Six anesthesia physical status modifiers are also listed in the appendix.
- Appendix I of the CPT manual provides a list of the generic testing code modifiers that are appended to the laboratory codes.
• The addition of a modifier to CPT and HCPCS codes does not guarantee reimbursement. A special report may be necessary if the service is rarely provided, unusual, variable or new.
• The special report should include pertinent information and procedure. The report should also describe the complexity of the patient’s symptoms, diagnosis and associated conditions and follow-up care.
• You will find this instruction in the CPT manual in the Special Report section.

• The entire list of modifiers is in CPT. To some coders this may infer an unrestricted application of the modifier with all CPT codes.
• There are limitations for reporting of certain CPT codes.
• There are limitations for reporting of certain modifies with specific CPT codes.
• For instance, modifier 57, decision for surgery, can only be appended to appropriate E/M codes and certain ophthalmological services codes found in the medicine chapter of CPT.
Some modifiers are informational only, i.e., -24, -25 and do not affect reimbursement but can determine if the service will be reimbursed or denied.

Other modifiers, such as:
- -22 for unusual procedural service
- -52 for reduced service
will usually equate to an increase or decrease in reimbursement.

Tips for Using Modifiers

• **-22 Increased Procedural Services**
  - When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient’s condition, physical and mental effort required).
  - **Note:** This modifier should not be appended to an E/M service.
    • Add to the basic procedure when the service provided is greater than usually required for the listed procedure. Use of this modifier allows the claim to undergo individual consideration.
    • Used to identify an increment of work that is infrequently encountered with a particular procedure and is not described by another code.
    • Use this modifier when surgical procedures require additional physician work due to complications or medical emergencies.
    • Documentation of medical necessity is a must, and a special report may be required.
-22 Increased Procedural Services (cont)

- Because providers have used this modifier frequently, many third-party payers simply ignore this modifier when it comes to a higher reimbursement. This modifier identifies the claim as one that needs individual consideration and manual review.

- Documentation of medical necessity should accompany the claim for review. All attachments to the claim for justification of the unusual services should explain the unusual circumstances in a concise, clear manner. The information for justification should be easy to locate within the attached documentation.

Note: This modifier is not to be used to report procedure(s) complicated by adhesion formation, scarring, and/or alteration of normal landmarks due to late effects of prior surgery, irradiation, infection, very low weight (neonates and infants less than 10 kg.) or trauma.
Tips for Using Modifiers

- **-23 Unusual Anesthesia**
  - Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier 23 to the procedure code of the basic service.
    - Use on basic service procedure codes (00100-01999).
    - Use when general anesthesia is administered in situations that typically do not require this level of anesthesia, but would not be sufficient under the circumstances.
    - Documentation of medical necessity should accompany the claim.
  - Claims submitted to Medicare, Medicaid or other third-party payers containing this modifier with no supporting documentation will typically be processed as if this modifier was not added to the procedure.

- **-24 Unrelated Evaluation and Management Service by the Same Physician during a Postoperative Period**
  - The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier 24 to the appropriate level of E/M service.
    - CMS allows this modifier to be added to E/M codes 99201-99499, and eye examination codes 92002-92014.
    - Modifier 24 should not be used for the medical management of a patient by the surgeon following surgery. Add this modifier to the E/M when the patient is being seen for an unrelated service to the major or minor surgical procedure performed by the same physician during the postoperative period.
    - When the patient is admitted to a Skilled Nursing Facility (SNF) for an unrelated condition in a global period, use this modifier with the appropriate SNF admitting code.
    - The diagnosis for the E/M service is almost always different than the diagnosis for the surgical procedure. However, this may not be true in a limited number of cases, such as utilizing same diagnosis at different anatomical sites. **Nevertheless, utilize this exception with caution.**
Tips for Using Modifiers

- **-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service**
  
  - It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided, or beyond the usual preoperative and postoperative care associated with the procedure that was performed.
  
  - A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date.

Tips for Using Modifiers

- **-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service (cont.)**
  
  - **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.
  
    - Use when the E/M is separate from that required for the procedure and a clearly documented significantly identifiable service was rendered.
    
    - When using this modifier on an E/M service on the same day as a procedure, the E/M service must have the key components, (history, exam and decision making), well documented.
    
    - Use this modifier on an initial hospital visit, an initial inpatient consult and a hospital discharge service when billed for the same date as an inpatient dialysis service.
    
    - Use on an E/M when a preventative care service was performed on the same date.
    
    - Use on an E/M representing a medically necessary significant, separately identifiable service was performed on the same date as routine foot care.
Tips for Using Modifiers

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service (cont.)

- Medicare will allow separate payment for two office visits provided on the same date, by the same physician, when each visit is rendered for an unrelated problem. Both visits must occur at different times of the day, and both visits must be medically necessary. This particular circumstance is considered rare, and requires -25 to be appended to the second visit.

- Medicare guidelines instruct coders to use -25 if the decision for surgery is made on the same day as a minor surgery such as those with a zero-to-10 day global period. Modifier 57 should be added to the appropriate level of E/M code when the initial decision to perform major surgery, such as those with a 90-day global period, is made during an E/M service on the same day of, or the day before the surgery.

- Documentation will be key when using the -25 modifier. The carrier will want to be sure that the E/M and procedure were in fact significant, separate, and identifiable. The documentation should show medical necessity and have a different diagnosis between the two services.

-26 Professional Component

- Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding the modifier 26 to the usual procedure number.

  - Add to the procedure code to report that only the professional component was performed.
  - Use when the professional only provided the interpretation of the diagnostic study or test performed. The interpretation of the diagnostic study or test is a patient specific service that is distinct, identifiable, written and signed.

- Certain procedures and services include both a technical and professional component. If the provider performs both components of the test or study, then the modifier is not usually required as all services included in the code were performed. If the provider performed only the professional component, append the -26 to the service code. If only the technical component was performed, append the TC modifier to the serviced code.
Tips for Using Modifiers

• -32 Mandated Services
  – Services related to mandated consultation and/or related services (e.g., third-party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.
    • Use when the physician is aware of a third-party involvement regarding mandated services.
    • Considered informational.
  – Very often if the commercial carrier is the third party mandating the service they will pay 100% of the allowable and the patient will not be required to pay their co-pay or deductible. This modifier has not effect on Medicare reimbursement.

Tips for Using Modifiers

• -33 Preventive Services
  – Modifier 33 has been created to allow providers to identify to insurance carriers that the service was preventive under applicable laws of The Patient Protection and Affordable Care Act (PPACA), and that patient cost-sharing does not apply.
    • Applicable for the identification of preventive services without cost-sharing in these four categories:
      1. Services rated “A” or “B” by the US Preventive Services Task Force.
      2. Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
      3. Preventive care and screenings for children as recommended by Bright Futures (American Academy of Pediatrics) and Newborn Testing (American College of Medical Genetics) as supported by the Health Resources and Services Administration; and
      4. Preventive care and screenings provided for women (not included in the Task Force recommendations) in the comprehensive guidelines supported by the Health Resources and Services Administration.
Tips for Using Modifiers

• **-33 Preventive Services (cont.)**
  • Used when the primary reason for the visit is to receive preventive services, unless the service is inherently preventive (e.g., a screening mammography or immunization).
  • This modifier may be used when a service was initiated as a preventive service, which then resulted in a conversion to a therapeutic service.
  • If multiple preventive medicine services are provided on the same day, the modifier is appended to the codes for each preventive service rendered on that day.

Tips for Using Modifiers

• **-47 Anesthesia by Surgeon**
  – Regional or general anesthesia provided by the surgeon may be reported by adding the modifier 47 to the basic service. (This does not include local anesthesia.)
  – **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures.
    • Use when the operating physician is administering the anesthesia.
    • This modifier denotes regional or general anesthesia only.
    • Use on the surgical code.
  – This modifier is not to be used by an anesthesiologist and is not to be used on an anesthesia code.
Tips for Using Modifiers

• **-50 Bilateral Procedure**
  – Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding the modifier 50 to the appropriate five digit code.
    • Bilateral procedures are procedures performed on both sides of the body during the same operative session. Medicare makes payment for bilateral procedures based on lesser of the actual charges, or 150 percent of the Medicare Physician Fee Schedule (MPFS) amount when the procedure is authorized as a bilateral procedure.
    • Modifiers LT (left side) and RT (right side) are not to be reported when the 50 modifier applies. Claims with the LT and RT modifiers will be returned to the provider (RTP) when modifier 50 applies.
    • When the -50 is reported, Medicare, along with most carriers will reduce the reimbursement for the second procedure by 50%. This means the reimbursement for the entire procedure will be paid at 150%. If a procedure is authorized for the 150 percent payment adjustment for bilateral procedures (payment policy indicator “1”) the procedure should be reported on a single line item with the 50 modifier.

Tips for Using Modifiers

• **-50 Bilateral Procedure (cont.)**
  • However, when a bilateral eligible code with a bilateral indicator of "3" is reported with modifier 50 and is not subject to reductions under the multiple procedure policy, the code will be eligible for reimbursement at 100% of the allowable amount for each side for a sum of 200% of the allowable amount not to exceed billed charges. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures.
    – Some carriers will allow the reporting of the procedure code as one line item with a -50 appended. Other carriers will want both procedures to be listed separately with the -50 on the second line item. Be sure the procedure code does not already consider bilateral procedures. If this is the case, no -50 will be necessary as the code already takes into consideration the bilateral procedure.
Tips for Using Modifiers

- **-51 Multiple Procedures**
  - When multiple procedures, other than E/M services, physical medicine and rehabilitation services, or provision of supplies (e.g., vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier 51 to the additional procedure or service code(s).
  - **Note:** This modifier should not be appended to designated add-on codes (see Appendix D).
    - Use this modifier to indicate that more than one surgical service was performed by the same physician, on the same patient, on the same date.
    - Use when more than one classification of wound repairs are performed on the same date.
    - For the delivery of twins, use this modifier for the birth of the second twin.

- **-51 Multiple Procedures (cont.)**
  - Multiple surgeries are separate procedures performed by the same provider on the same patient at the same operative session. Medicare, along with commercial carriers, will allow the 50% multiple surgical payment reduction because the major procedure includes payment for the preparation of the patient. The major procedure is paid at 100% and the additional procedures are paid at 50%.
  - Do not use -51 with add-on codes. Add-on codes are procedures performed in addition to the main procedure. These codes represent procedures which cannot be performed alone.
Tips for Using Modifiers

• **-52 Reduced Services**
  
  – Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
  
  – **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).
    
    • Use when the service or procedure has been partially reduced or eliminated at the physician’s election.
    
    • Use to report that a service or procedure is being performed at a lesser level than what the code indicates.
    
    • Documentation must explain the circumstances surrounding the reduction of services.

Tips for Using Modifiers

• **-52 Reduced Services (cont.)**
  
  – The use of this modifier may effect reimbursement. -52 is not used to show a reduction in your fees for a patient due to their inability to pay the full charge. This modifier is used when the entire code was performed at a lesser level and no other code represents what was truly done.
Tips for Using Modifiers

• -53 Discontinued Procedure
  – Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.
  – This circumstance may be reported by adding the modifier 53 to the code reported by the physician for the discontinued procedure.

Tips for Using Modifiers

• -53 Discontinued Procedure (cont.)
  – Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient’s anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).
    • Use when a procedure was actually started but was discontinued before completion due to a risk to the patient.
    • Use this modifier to report a procedure that was discontinued after anesthesia was administered.
  – Use this modifier when extenuating circumstances exist that could threaten the well being of the patient.
Tips for Using Modifiers

• -54 Surgical Care Only
  – When 1 physician or other qualified health care professional performs
    a surgical procedure and another provides preoperative and/or
    postoperative management, surgical services may be identified by
    adding the modifier 54 to the usual procedure number.
    • May be used with surgical codes only.
    • Use when the surgeon does not intend to provide any of the postoperative
      care.
    • An agreement for the transfer of care must exist.

• -55 Postoperative Management Only
  – When 1 physician or other qualified health care professional
    performed the postoperative management and another has performed
    the surgical procedure, the postoperative component may be identified
    by adding the modifier 55 to the usual procedure number.
    • Use with surgical codes only to indicate that only the postoperative care
      was provided.
    • Used to report that the provider did not perform the surgical care, but did
      perform a part of the postoperative care.

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Tips for Using Modifiers

• **-56 Preoperative Management Only**
  - When 1 physician or other qualified health care professional performed the preoperative care and evaluation, and another performed the surgical procedure, the preoperative component may be identified by adding the modifier 56 to the usual procedure number.
    • Use with surgical codes only to indicate that only the preoperative care was provided.
  - Sometimes more than one provider will perform services during the global period. This may occur when one provider performs the surgical procedure only, then transfers care to another for the postoperative care. These modifiers are to be used on surgical codes only, and indicate which part of the global package a particular provider performed.

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Tips for Using Modifiers

• **-57 Decision for Surgery**
  - An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding the modifier 57 to the appropriate level of E/M service.
    • Use this modifier on the E/M that resulted in a decision to perform a major surgery and the surgery will be performed within the next 24 to 72 hours depending on the insurance plan.
    • Some third-party payers will accept this modifier for an E/M that resulted in a decision for performance of a minor surgical procedure.
    • Medicare only allows this modifier for E/M that resulted in a decision for a surgery with a 90-day global period.
  - This modifier helps to keep the initial E/M that resulted in a decision for surgery out of the global package and reimbursed separately from the global. This service is not considered the pre-op and should not be included as such.

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**Tips for Using Modifiers**

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<tr>
<th>-58</th>
<th>Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional during the Postoperative Period</th>
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<tbody>
<tr>
<td></td>
<td>- It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure.</td>
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<tr>
<td></td>
<td>- This circumstance may be reported by adding the modifier 58 to the staged or related procedure.</td>
</tr>
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**Tips for Using Modifiers**

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<thead>
<tr>
<th>-58</th>
<th>Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional during the Postoperative Period (cont.)</th>
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<tbody>
<tr>
<td></td>
<td>- <strong>Note:</strong> For treatment of a problem that requires a return to the operating or procedure room (e.g., unanticipated clinical condition), see modifier 78.</td>
</tr>
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<td></td>
<td>- Use on the second procedure when it is a staged procedure during the postoperative period.</td>
</tr>
<tr>
<td></td>
<td>- Use when a second related procedure is necessary during the postoperative and that procedure is more extensive than the first procedure.</td>
</tr>
<tr>
<td></td>
<td>- This modifier is not to be used for procedures to correct a complication. See modifier -78 in these cases.</td>
</tr>
</tbody>
</table>

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Tips for Using Modifiers

- **-59 Distinct Procedural Service**
  - Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other than E/M services performed on the same day. Modifier 59 is used to identify procedures/services other than E/M services that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.
  
  However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances should modifier 59 be used.

- **-59 Distinct Procedural Service (cont.)**
  - **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.
  - CPT® considers this the modifier of last resort. When no other modifier describes the situation perhaps this one will.
  - Use when a combination of codes is being reported that are not usually reported at the same time. This may represent:
    - Different session or patient encounter
    - Different procedure or service/same day
    - Different site or organ system
    - Separate incision/excision
    - Separate lesion
    - Separate injury
Tips for Using Modifiers

- **-59 Distinct Procedural Service (cont.)**
  - This modifier is used to report that a procedure is distinct and separate from another. Documentation must clearly indicate that the procedures are distinct and separate from the others. This modifier allows the code to bypass edits. Therefore appropriate documentation will be essential.

- **-62 Two Surgeons**
  - When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associate add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons.
  - Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added.
Tips for Using Modifiers

-62 Two Surgeons (cont.)

- **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.
  - Use on the surgical code by each surgeon for reporting services if the services of two physicians are required to manage a specific surgical code.
  - Use when the individual skills of two different physicians, usually but not always of different specialties, are required to perform one surgical procedure. Usually this need is due to the complexity of the surgical procedure.
  - Co-surgery refers to a single procedure requiring the skills of two surgeons of different specialties. Medicare allows 125% of the fee schedule for these procedures. This amount is split evenly between the two surgeons. Medicare has a list of approved procedures that allow for co-surgery.
  - Some third-party payers will deny the co-surgery claim if the physicians were of the same specialty.

-63 Procedure Performed on Infants less than 4 kg

- Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number.
  - **Note:** Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20005-69990 code series. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, and Medicine sections.
  - Use when a surgical procedure is performed on an infant or neonate that weighs less than 4 kg.
  - May only be used with some codes in the surgery section. See Appendix E.
  - Weight should be documented when using this modifier.
  - This modifier is appended to the surgical procedure code for some procedures performed on infants or neonates weighing 4kg or less, and assists in showing the increased complexity of these procedures when performed on patients of this size.
Tips for Using Modifiers

• **-66 Surgical Team**
  - Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the “surgical team” concept. Such circumstances may be identified by each participating individual with the addition of the modifier 66 to the basic procedure number used for reporting services.
    • Used for highly complex procedures requiring the skills of three or more surgeons.
    • Usually the surgeons have different skills and are of different specialties.
    • Each physician on the surgical team will report the same surgical code with this modifier.
  - This modifier is reserved for surgical teams of three or more. The procedures involved are highly complex and require the skills of different specialties. Each member of the team will report the shared surgical code with the -66 modifier. Documentation will indicate which part of the surgical procedure was performed by which surgeon.

Tips for Using Modifiers

• **-76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional**
  - It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding the modifier 76 to the repeated procedure/service.
    - **Note:** This modifier should not be appended to an E/M service.
      • Use this modifier when a procedure or service is medically necessary to repeat and is repeated by the same provider.
      • Sometimes the repeated procedure or service occurs on the same date.
  - The -76 is appended to the repeated procedure to report that the procedure was subsequent to the original procedure. This modifier helps to indicate on the claim that this procedure is not a duplicate charge.
Tips for Using Modifiers

• -77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional
  – It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This situation may be reported by adding modifier 77 to the repeated procedure/service.
  – **Note:** This modifier should not be appended to an E/M service.
    • Use when a procedure was medically necessary to repeat and was repeated by a different provider.
    • Sometimes the repeated procedure or service occurs on the same date.
  – This modifier is added to the repeated procedure or service to indicate that a basic procedure or service was performed by another provider and needed to be repeated by a different provider.

• -78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
  – It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)
    • Use when treatment for a complication requires a return trip to the operating room.
    • Use on surgical codes only to indicate that another procedure was performed during the postoperative period of the initial procedure, was related to the first procedure, and required the use of the operating or procedure room.
  – This modifier is used on the surgical code when the subsequent procedure is related to the first and requires the use of an operating or procedure room. Failure to use this modifier when appropriate could result in a loss of reimbursement. Do not use this modifier if the treatment does not require a return trip to the operating or procedure room.
Tips for Using Modifiers

- **-79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional during the Postoperative Period**
  - The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier 79. (For repeat procedures on the same day, see modifier 76.)
    - Use on surgical codes to indicate that an unrelated procedure is being performed by the same provider during the postoperative period of the original procedure.
    - This modifier is used to report an unrelated procedure being performed by the same provider during the postoperative period of the original procedure. A different diagnosis should be reported. Failure to use this modifier when appropriate could result in denial of the subsequent procedure.

- **-80 Assistant Surgeon**
  - Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).
    - Use on the appropriate surgical codes. The codes must match the codes reported by the primary surgeon.
    - May be used on claims with other modifiers such as -50 and -51.
  - Medicare allows assistant surgeons for certain procedures only. If an assistant surgeon submits a claim for unapproved procedures it will result in a denial of the claim.
Tips for Using Modifiers

• -81 Minimum Assistant Surgeon
  – Minimum surgical assistant services are identified by adding the modifier 81 to the usual procedure number.
    • Used when a second or third assistant is required for a procedure.
    • Use when the assistant-at-surgery is not present for the entire procedure.
  – At times, while a primary operating physician may plan to perform a surgical procedure alone, during an operation circumstances may arise that require the services of an assistant for a relatively short period of time and the use of the modifier is utilized. CMS rarely recognizes this modifier except in extreme cases.

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Tips for Using Modifiers

• -82 Assistant Surgeon (when qualified resident surgeon not available)
  – The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number.
    • Used to indicate a surgical assist when a qualified resident is not available.
    • When using this modifier the assistant must provide documentation that a qualified resident was not available for the procedure and why the resident was not available.
  – Many hospitals have residency programs. Medicare Part B will not pay for a resident used as an assistant. Medicare Part B only allows this modifier by physicians that are not part of a residency or fellowship program.

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Tips for Using Modifiers

• **-90 Reference (Outside) Laboratory**
  
  – When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding the modifier 90 to the usual procedure number.
  
  • Add to the usual procedure code when laboratory procedures are performed by a party other than the treating or reporting provider.
  
  – Medicare will not pay provider for laboratory procedures that are not performed in the providers' lab. By using this modifier you are indicating that the lab was not performed in the reporting provider’s (s’) office; therefore no reimbursement is expected.

Tips for Using Modifiers

• **-91 Repeat Clinical Diagnostic Laboratory Test**
  
  – In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of the modifier 91.
  
  – **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

  • Use on the laboratory code when it is medically necessary to repeat a lab test on the same date.
  
  • Do not use this modifier for lab tests that take into consideration multiple testing.
  
  • Do not use this modifier to confirm a test result.
Tips for Using Modifiers

• -92 Alternative Laboratory Platform Testing
  – When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701-86703, and 87389). The test does not require permanent dedicated space; hence by its design it may be hand carried to or transported to the vicinity of the patient for immediate testing at the site, although location of the testing is not in itself determinative of the use of this modifier.
    • Use to indicate the test is a kit and does not require dedicated space.
    • This test is a kit that is for single use and disposable.

Tips for Using Modifiers

• -95 Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
  – Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Modifier 95 may only be appended to the services listed in Appendix P. Appendix P is the list of CPT codes for services that are typically performed face-to-face, but may be rendered via a real-time interactive audio and video telecommunications system.
Tips for Using Modifiers

-99 Multiple Modifiers

- Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

- Medicare’s CMC 1500 form allows for up to 4 modifiers per line item. If you need to use more than 4 modifiers per line item, append this modifier to indicate the need for more than 4 modifiers.

- If this modifier is utilized, you must document in box 19 of the CMS 1500 claim form which modifiers the -99 is representing.

HCPCS Modifiers

Like CPT, HCPCS has national modifiers which begin with two letters (A1-VP). Each section of the HCPCS manual lists the modifiers typically reported with that section. Modifiers most applicable to this course currently include the modifiers in the following slide.
### A modifiers
(AA-AZ) describe the individual providing a service such as AH used by a clinical psychologist to report services.

### B modifiers
(BP-BU) describe beneficiary informed consent with respect to purchase/rental options.

### C modifiers
(CC) describe procedure codes that were changed either for administrative reasons or because of an incorrectly filed code.

### E modifiers
(ET-ET) describe location (E1-E4—eyelid), end-stage renal disease (ESRD) services and emergency services.

### F modifiers
(F1-F9, FP) describe location (FA-F9—hands) or (PP-service provided as part of Medicaid Family Planning Program).

### G modifiers
(G1-GX) describe most recent U&I (G1-G6) and end-stage renal disease (ESRD) (G6) and dialysis sessions in one month; GA indicates waiver of liability statement on file, and GC, GE which describe services performed by a resident under the supervision of a teaching physician.

### K modifiers
(K0-K4, KA-KP) correspond to prosthetics/equipment (K0-K4, KA-KN) and drug unit dose formulation (KO-KQ).

### L modifiers
(LC-LT) correspond to location (LC, LD, LM, LT), leasing/rental (LL), laboratory services (LR) and intraocular lens implants (LS).

### M modifiers
(MS) correspond to six-month maintenance and servicing fee for parts and labor not covered under manufacturer/supplier warranty.

### N modifiers
(NR, NU) describe conditions of durable medical equipment.

### P modifiers
(PL) describe progressive addition lenses.

### Q modifiers
(Q0-Q9, QC-QZ) describe temporary procedures, services and supplies, such as QW for CLIA-waived test.

### R modifiers
(RC-RT) describe location (RC, RI, RT) or services (RA, RB, RD, RE, RR).

### S modifiers
(SF, SG) describe second opinion by professional review organization (PRO) (SF) or Ambulatory Service (ASC) service (SG).

### T modifiers
(TA-T9, TC) describe location TA-T9 (foot) or technical component (TC).

### U modifiers
(UE) describes used durable medical equipment.

---

**X Modifiers**

<table>
<thead>
<tr>
<th>X modifiers</th>
<th>-X(EPSU) modifiers, define specific subsets of the -59 modifier</th>
</tr>
</thead>
</table>

CMS has defined four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (-59 modifier) as follows:

- **XE Separate Encounter**, A Service That Is Distinct Because It Occurred During A Separate Encounter
- **XS Separate Structure**, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
- **XP Separate Practitioner**, A Service That Is Distinct Because It Was Performed By A Different Practitioner
- **XU Unusual Non-Overlapping Service**, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

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X Modifiers

• These modifiers, collectively referred to as -X{EPSU} modifiers, define specific subsets of the -59 modifier. CMS will not stop recognizing the -59 modifier but notes that CPT instructions state that the -59 modifier should not be used when a more descriptive modifier is available. CMS will continue to recognize the -59 modifier in many instances but may selectively require a more specific -X{EPSU} modifier for billing certain codes at high risk for incorrect billing.

• The combination of alternative specific modifiers with a general less specific modifier creates additional discrimination in both reporting and editing. As a default, at this time CMS will initially accept either a -59 modifier or a more selective -X{EPSU} modifier as correct coding, although the rapid migration of providers to the more selective modifiers is encouraged. However, these modifiers are valid modifiers even before national edits are in place, so contractors are not prohibited from requiring the use of selective modifiers in lieu of the general -59 modifier when necessitated by local program integrity and compliance needs.

When to Use Modifiers XE, XP, XS, XU

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Modifier</th>
<th>Reasoning/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery operative sessions: One surgery procedure at 9AM and one at 6PM. Physical therapy sessions: Group therapy services (97150) at 10AM and therapeutic exercises (97110) at 4PM.</td>
<td>XE</td>
<td>Separate encounters. Same date of service.</td>
</tr>
<tr>
<td>Patient is seen by her OB-GYN. During the exam, the doctor notes an issue and requests his partner, a Perinatologist, exam the patient as well. Patient is under treatment for breast cancer. During her appointment, she is seen by two physicians in the practice – the Medical Oncologist and the Radiation Oncologist.</td>
<td>XP</td>
<td>Same date of service. May or may not be the same encounter. May or may not be different specialties. Both practitioners fall under same TIN.</td>
</tr>
</tbody>
</table>
## When to Use Modifiers XE, XP, XS, XU

<table>
<thead>
<tr>
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<th>Modifier</th>
<th>Reasoning/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection into tendon sheath, elbow (20550) and injection into tendon sheath, knee (20550-XS)</td>
<td>XS</td>
<td>Separate structure or organ. Different anatomical site. Same encounter.</td>
</tr>
<tr>
<td>A diagnostic procedure is performed. Based on the findings, a therapeutic and/or surgical procedure is required on the same day. For example, diagnostic cardiac catheterization is followed by a medically necessary cardiac procedure.</td>
<td>XU</td>
<td>Same encounter. Same practitioner. Same anatomical site, structure, or organ.</td>
</tr>
</tbody>
</table>

---

## Modifiers for Level II National Codes

**Note**—this table includes a partial listing of these modifiers. For a complete list, refer to HCPCS Level II code book.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>-AA</td>
<td>Anesthesia services performed personally by anesthesiologist.</td>
</tr>
<tr>
<td>-AD</td>
<td>Medical supervision by a physician: more than four concurrent anesthesia procedures.</td>
</tr>
<tr>
<td>-AI</td>
<td>An admitting physician will append modifier AI to distinguish the admitting physician from other providers providing specialty care to Medicare patients.</td>
</tr>
<tr>
<td>-CC</td>
<td>Procedure code change. The carrier will add &quot;CC&quot; when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed.</td>
</tr>
<tr>
<td>-EP</td>
<td>Service provided as part of Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) program.</td>
</tr>
<tr>
<td>-GA</td>
<td>Waiver of liability statement on file.</td>
</tr>
<tr>
<td>-GC</td>
<td>This service has been performed in part by a resident under the direction of a teaching physician.</td>
</tr>
<tr>
<td>-GE</td>
<td>This service has been performed by a resident without the presence of a teaching physician under the primary care exception.</td>
</tr>
<tr>
<td>-GY</td>
<td>Item or service statutorily excluded or does not meet the definition of any Medicare benefit.</td>
</tr>
<tr>
<td>-GZ</td>
<td>Item or service expected to be denied as not reasonable and necessary.</td>
</tr>
<tr>
<td>-LT</td>
<td>Left side. Use to identify procedures performed on the left side of the body.</td>
</tr>
<tr>
<td>-PT</td>
<td>Colonoscopy screening test; converted to diagnostic test or other procedure.</td>
</tr>
<tr>
<td>-QW</td>
<td>CLIA-waived test.</td>
</tr>
<tr>
<td>-RT</td>
<td>Right side. Use to identify procedures performed on right side of body.</td>
</tr>
<tr>
<td>-SF</td>
<td>Ambulatory surgical center (ASC) facility service.</td>
</tr>
<tr>
<td>-TC</td>
<td>Technical Component. Under certain circumstances a charge may be made for the technical component alone. Under those circumstances, the technical component charge is identified by adding modifier -TC. The charge data from portable X-ray suppliers will then be used to build customary and prevailing profiles.</td>
</tr>
</tbody>
</table>
### Anesthesia Physical Status Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>A normal healthy patient</td>
</tr>
<tr>
<td>P2</td>
<td>A patient with mild systemic disease</td>
</tr>
<tr>
<td>P3</td>
<td>A patient with severe systemic disease</td>
</tr>
<tr>
<td>P4</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
</tr>
<tr>
<td>P5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
</tr>
<tr>
<td>P6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
</tr>
</tbody>
</table>

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### MODIFIER CODING QUIZ

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1. Dr. Jones performed an appendectomy on William Tell. However, the operation took twice as long as usual because William weighs 375 pounds.

Which modifier should be appended to the surgical procedure?

-22
2. Dr. Williams performed a biopsy on the right external ear of Misty Johnson, a 71-year-old female.

Which HCPCS modifier will Medicare require you to append to the procedure code?

RT
3. Lucy Hammons, a 45-year-old female, goes to see Dr. Velasquez at the referral of her family physician, Dr. Phil, for his opinion as to whether or not she needed surgery.

After the evaluation and Lucy’s agreement, Dr. Phil schedules surgery for Monday.

Which modifier should be appended to Dr. Phil’s consultation code for today’s evaluation?

-57
4. Kris Kringle, a 50-year-old male, comes to see Dr. Snow for a complete physical examination, required by his insurance carrier.

Which modifier should be appended to the procedure code?

-32
5. Carlo Monterey, a 20-year-old male, hurt his shoulder while camping. The clinic in the area took the x-ray, but did not have a radiologist, so Carlo brought the films to Dr. Daniel for interpretation and evaluation.

Which modifier should Dr. Daniel's coder append to the code for the x-rays?

-26
6. Dr. Welby and his surgical team began the pancreatic transplantation procedure on MariLou.

Once the incision had been made, the patient’s heartbeat became erratic and could not be brought back under control, so the procedure was discontinued. The procedure code reported requires two modifiers.

-53; -66
7. Removal of foreign body, upper arm or elbow area; deep, repeat procedure by same physician, left side.

-76, LT
8. Dr. Jordan performed a bilateral osteotomy on the shaft of Mr. Stone’s femur. Another surgeon performed the same procedure on him two weeks ago but was unsuccessful, so Dr. Jordan repeated the procedure.

As an expert in this procedure, he was brought in to perform the surgery only and will not be involved in any preoperative or postoperative care of the patient.
9. The Patient Protection and Affordable Care Act (PPACA) requires health insurance coverage of preventive services and immunizations without patient cost share. Which modifier would be appropriate for this designation?
10. A patient had a lesion removed. The results revealed a malignancy. The patient was then returned to the operating room the next week for excision of the malignancy. What modifier would be appropriate to reflect this return to the operating room within the post-operative period?

-58
11. The laboratory receives the first specimen labeled tissue from left breast from the OR on a patient undergoing a mastectomy. The second specimen is received approximately 45 minutes later. Both specimen undergo pathological level V examination for the evaluation of clear margins and are assigned a pathological diagnosis.

Which modifier would be used for the second specimen?
12. You are certain that the services requested by a Medicare patient are not covered (deemed by Medicare as not medically necessary). Which modifier would be used to indicate that you have a properly completed ABN on file?

-GA
Questions?

• Thank you for your attendance!

• Get your questions answered on PMI's Discussion Forum:
  http://www.pmimd.com/pmiForums/rules.asp