

# MODIFIERS - KNOW WHEN AND WHY TO USE THEM

JAN HAILEY, MHL, CMC, CMIS, CMOM, CMCO

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## LEARNING OBJECTIVES

- Definition and proper use of modifiers
- CPT guidelines related to modifier usage
- Negative impacts of modifiers
- Impact of modifiers on reimbursement
- Explanation of HCPCS modifiers

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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 and state programs such as Medicare and Medicaid.

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## INTRODUCTION

- 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.

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## DEFINITION

- Modify is defined as changing something slightly, especially in order to make it more suitable for a particular purpose.
- A modifier is a two-digit code that provides the reporting physician a way to indicate that a service performed has been altered by some specific circumstance but has not changed in its definition or code.
- Knowing how to correctly use modifiers will reduce the risk of lost revenue and improve coding compliance.
- Modifiers can be the difference between full reimbursement and reduced reimbursement – or denial.

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## MODIFIER INDICATIONS

- A service or procedure has both a professional and technical component.
- A service or procedure was performed by more than one physician and/or in more than one location
- A service or procedure has been increased or reduced.
- Only part of a service was performed
- A bilateral or unilateral procedure was performed
- A service or procedure was provided more than once
- Unusual events occurred
- A service was provided during a global period but is not included as part of the global reimbursement

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- There are **two types** of modifiers:
  - Informational modifiers that **do not** impact reimbursement
  - Pricing or payment modifiers that **always** impact reimbursement
- There are **two levels** of modifiers used to alter a procedure
  - Level I Modifiers – CPT Modifiers are two digits and updated by the AMA (American Medical Association)
  - Level II Modifiers – HCPCS Modifiers are alpha numeric characters and are updated by CMS.

## TYPES OF MODIFIERS

Informational  
Pricing

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## MODIFIERS AND PAYERS

- There will be times when CMS and commercial payers use modifiers differently than the way CPT intended.
- A clear understanding of the payer's rules is necessary in order to assign the modifier correctly.
- For instance, the appropriate use of -57 can be confusing. While the CPT manual defines this modifier as an E/M service that resulted in the initial decision to perform surgery, Medicare states that it should be used to indicate that the E/M service performed the **day before or day of the surgery** resulted in the decision for a **major** surgery.

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## MODIFIERS AND PAYERS

- Even though CMS sets national guidelines, individual carriers are allowed to interpret many of these guidelines for their own region.
- Services and procedures allowed by one carrier may or may not be allowed by another.
- If more than one modifier is needed, list the payment modifiers first.

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## ANESTHESIA 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.
- **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.

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## GLOBAL SURGERY MODIFIERS

- **24** – Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period
- **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
- **54** – Surgical Care Only
- **55** – Postoperative Management Only
- **56** – Preoperative Management Only

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## GLOBAL SURGERY MODIFIERS

- **57** – Decision for Surgery
- **58** – Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
- **63** – Procedure Performed on Infants less than 4 kg
- **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
- **79** – Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional during the Postoperative Period

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## ASSISTANT SURGERY MODIFIERS

- **AS** – physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
- **80** – Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).
- **81** – Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.
- **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(s).

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## SURGICAL MODIFIERS

- **22** – Increased Procedural Services
- **50** – Bilateral Procedure
- **51** – Multiple Procedures
- **52** – Reduced Services
- **53** – Discontinued Procedure
- **62** – Two Surgeons
- **66** – Surgical Team

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## **SURGICAL MODIFIERS**

- **73** – Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia
- **74** – Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia
- **PA** – surgical or other invasive procedure on wrong body part
- **PB** – surgical or other invasive procedure on wrong patient
- **PC** – wrong surgery or other invasive procedure on patient

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## **LABORATORY MODIFIERS**

- **90** – Reference (Outside) Laboratory
- **91** – Repeat Clinical Diagnostic Laboratory Test
- **92** – Alternative Laboratory Platform Testing
- **QW** – Clinical Laboratory Improvement Amendments (CLIA) waived test

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## TELEHEALTH SERVICES MODIFIERS

- **GQ** – via asynchronous telecommunications system (Alaska or Hawaii)
- **95** - Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
- **G0** to be appended on claims for telehealth services that are for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

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## THERAPY MODIFIERS

- Used to identify type of therapy service and level of functional impairment.
- Outpatient Therapy Code Modifiers: Identify discipline of plan of care under which service is delivered.
- **96** – Habilitative Services
- **97** – Rehabilitative Services

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## OTHER CPT MODIFIERS

- **26** – Professional Component
- **27** – Multiple Outpatient Hospital E/M Encounters on the Same Date
- **32** – Mandated Services
- **33** – Preventive Services
- **59** – Distinct Procedural Service
- **76** – Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
- **77** – Repeat Procedure by Another Physician or Other Qualified Health Care Professional

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## HCPCS LEVEL II MODIFIERS

- **GA** – waiver of liability statement issued as required by payer policy, individual case
- **GX** – notice of liability issued, voluntary under payer policy
- **GY** – item or service statutorily excluded or does not meet the definition of any Medicare benefit
- **GZ** – item or service expected to be denied as not reasonable and necessary

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- **E1** – Upper left, eyelid
- **E2** – Lower left, eyelid
- **E3** – Upper right, eyelid
- **E4** – Lower right, eyelid
- **FA** – Left hand, thumb
- **F1** – Left hand, second digit
- **F2** – Left hand, third digit
- **F3** – Left hand, fourth digit
- **F4** – Left hand, fifth digit
- **F5** – Right hand, thumb
- **F6** – Right hand, second digit
- **F7** – Right hand, third digit
- **F8** – Right hand, fourth digit
- **F9** – Right hand, fifth digit
- **LC** – Left circumflex coronary artery
- **LD** – Left anterior descending coronary artery
- **LM** – Left main coronary artery
- **LT** – Left Side
- **RC** – Right coronary artery
- **RI** – Ramus intermedius coronary artery
- **RT** – Right Side
- **TA** – Left foot, great toe
- **T1** – Left foot, second digit
- **T2** – Left foot, third digit
- **T3** – Left foot, fourth digit
- **T4** – Left foot, fifth digit
- **T5** – Right foot, great toe
- **T6** – Right foot, second digit
- **T7** – Right foot, third digit
- **T8** – Right foot, fourth digit
- **T9** – Right foot, fifth digit

## ANATOMICAL MODIFIERS

- Anatomical modifiers designate the area or part of the body on which the procedure is performed
- Assist in prompt, accurate adjudication of claims.

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## HCPCS MODIFIERS

- AE, AF, AG, AI, AK, AM, AO, AT, AZ, BL, CA, CB, CG, CP, CR, CT, DA, ET, FB, FC, FX, G7, GC, GE, GG, GJ, GU, J1, J2, J3, JC, JC, JD, JW, KX, L1, M2, PD, PI, PO, PN, PS, PT, Q0, Q1, Q3, Q4, Q5, Q6, RD, RE, SC, SF, SS, SW, TC, TS, UJ, UN, UP, UQ, UR, US, XE, XP, XS, XU, ZA, ZB, ZC

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## X MODIFIERS

- **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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## COVID-19

- **Modifier CS**
- CMS now waives cost-sharing (coinsurance and deductible amounts) under Medicare Part B for Medicare patients for certain COVID-19 testing-related services.

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## PERFORMANCE MEASURE MODIFIERS

- **1P** - Performance Measure Exclusion Modifier due to Medical Reasons
- **2P** - Performance Measure Exclusion Modifier due to Patient Reasons
- **3P** - Performance Measure Exclusion Modifier due to System Reasons
- **4P** - Performance Measure Reporting Modifier – action not performed, reason not otherwise specified

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## NCCI EDITS

- The purpose of the NCCI Procedure-to-Procedure (PTP) edits is to prevent improper payment when incorrect code combinations are reported
- The NCCI contains one table of edits for physicians/practitioners and one table of edits for outpatient hospital services
- The Column One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table have been combined into one table and include PTP code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual.
- The purpose of the NCCI MUE program is to prevent improper payments when services are reported with incorrect units of service
- The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services

(CMS,2018)

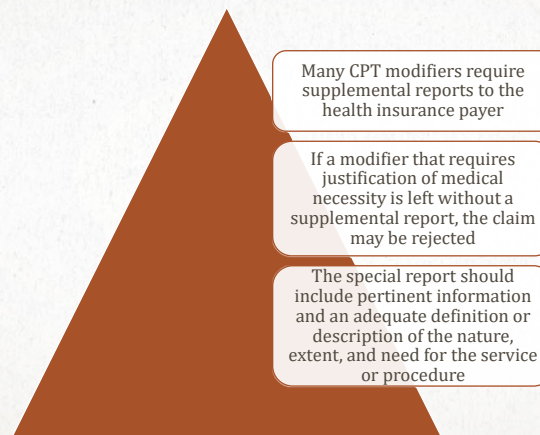
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## NCCI EDITS

- Adding modifiers to CPT codes can bypass NCCI edits for Medicare payments, but they're often misapplied
- NCCI edits are triggered to prevent improper payments when code pairs that should not be reported together are used
- Modifier 59 (distinct procedural service) is frequently misused to bypass services that are not normally reported together

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## SUPPLEMENTAL REPORTS



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## CORRECT USAGE OF MODIFIERS

- Determining correct modifier assignment can be very frustrating if you do not know the rules to apply
- If the medical record documentation does not support the use of a specific modifier the physician risks denial of the claim based on lack of medical necessity
- Misused modifier usage could lead to possible fraud and/or abuse penalties if the medical record documentation is reviewed by third-party payers including Medicare and Medicaid
- The use of modifiers is part of Medicare's correct coding Initiative
- Without modifiers, payer edits would stop the claim from being paid or result in incorrect underpayment or over payments
- Be diligent in knowing and using modifiers correctly!

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## REFERENCES

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