Modifiers
The Rest of the Story

Disclaimer

This is not an all inclusive list of every modifier; this is an overview of many modifiers and their intended usage.

This material is designed to offer basic information on the use of modifiers in coding. This information is based on the experience, training and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the instructor does not accept any responsibility or liability with regard to errors, omission, misuse or misinterpretation. This handout is intended as an educational guide and should not be considered a legal/consulting opinion.
CPT® Coding

- CPT® codes identify a particular procedure or service
- If a specific CPT® does not exist that identifies the procedure or service, an unlisted code must be utilized
- Coding is the translation between the physician’s written word and the dictionary used by payers to interpret them into numbers

What Do the Codes ‘Say’?

- A patient comes in for a reason which translates into the diagnosis(s) code
- A service is provided or supply is given which translates into a CPT® or HCPCS Level II code
  - This tells the story to the payer about what was done and why it was done

THE CODING NEEDS TO TELL THE RIGHT STORY
Lost in the Maze

- Don’t know which way to go
- Instructions vary
- Even the carrier seems unsure
- Learn how and when to apply

The Role of the Modifier

- Provide more information
- Clarify
- Expand upon
- Enhance Specificity
- Identify separation
- …they add to…or CHANGE the story
Types

- Informational Modifiers
- Payment impacting modifiers
- Status of patient modifier
- Type of service
  - Both CPT® modifiers and HCPCS Level II modifiers
    - Many commercial payers do not require HCPCS Level II modifiers
- All modifiers have a vital role in accurate coding.
- NOT all payers recognize modifiers
- KNOW your payers!

Payment

- Adding a modifier may get a claim paid
- MUST make sure the modifier should be added
- Adding a modifier JUST to get it paid, if not supported, is fraud

Failure to use a modifier when appropriate may risk lost reimbursement; over-utilizing or using a modifier for payment when not appropriate can put the physician and practice at risk.
Denials

• Monitor and track denials that occur due to modifier issues; to identify how your payers recognize modifiers and when
  – When a denial is received that indicates a modifier is needed
    • EASY fix: apply modifier
    • NOT correct
      – This denial really states that if a modifier was utilized, if appropriate and supported by documentation on this particular day for this particular patient for a particular reason, this claim may have been covered
        » Staff working denials MUST be very familiar with the use and needs of modifiers

Let’s Get Started
Anatomical Modifiers

Modifiers TA-T9, FA-F9: To identify that procedures were done on separate fingers or toes

- ONLY appropriate on procedures and services, NOT diagnosis codes or E/M codes
- If hammertoes are repaired on all toes, you could report the same code 10 times, identifying each toe individually with a modifier

Anatomical Modifiers

Modifier RT, LT: To identify that procedures were done on separate ‘sides’ of the body

- ONLY appropriate on procedures and services, NOT diagnosis codes or E/M codes
- Some payers would also rather see an RT, LT, and not the 50 for bilateral, must know what the payers want
- Lesion removed from right arm, excision taken from left arm, modifier RT and LT will identify that they were from a different location
Anatomical…and the Eyelids

- E1  Upper left
- E2  Lower left
- E3  Upper right
- E4  Lower right

Examples of Anatomical Modifiers

- Blepharoplasty done on the right and left upper eyelid during the same operative episode
  - The procedure should be reported on two separate line items; one with an E1 and one with an E3 modifier
    - While reimbursement would face multiple procedure reduction rules; expected reimbursement would be 100% for the first and 50% for the second.
    - Failure to use a modifier could result in a denial of the second procedure; as can appear to be a duplicate
- Hammertoe repair done on the right second, third, and fourth toe
  - T6, T7, T8 should be reported with the hammertoe repair, each on a separate line item
    - Again, this clarifies that it is not a duplicate, but three distinct and separate procedures
      - Expected reimbursement would be 100% of the first and 50% of both the second and the third procedure
      - Without the modifiers; there is a potential risk of only being paid for the initial procedure and the others denied as a duplicate claim
### Surgical Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>Staged or related procedure in the post-op period by the same physician</td>
</tr>
<tr>
<td></td>
<td>Patient had a lumpectomy and after pathology, it was determined that</td>
</tr>
<tr>
<td></td>
<td>mastectomy needed to be performed. Mastectomy, more extensive and related</td>
</tr>
<tr>
<td></td>
<td>to the initial surgery, modifier 58, identifies that it is staged/related in</td>
</tr>
<tr>
<td></td>
<td>the post-op period.</td>
</tr>
<tr>
<td>78</td>
<td>Return to the OR for a related procedure during the post-op period</td>
</tr>
<tr>
<td></td>
<td>Patient had open heart surgery, during hospitalization, began bleeding and</td>
</tr>
<tr>
<td></td>
<td>had to be taken BACK to the OR for more surgery. It was NOT &quot;STAGED,&quot; it is</td>
</tr>
<tr>
<td></td>
<td>NOT more extensive than initial surgery, modifier 78 identifies a return to</td>
</tr>
<tr>
<td></td>
<td>the OR.</td>
</tr>
<tr>
<td>79</td>
<td>Return to the OR for an unrelated procedure during the post-op period</td>
</tr>
<tr>
<td></td>
<td>Patient had surgery to repair a fractured hip. During recovery, he slipped</td>
</tr>
<tr>
<td></td>
<td>and fell fracturing his wrist and had to have an ORIF performed, modifier</td>
</tr>
<tr>
<td></td>
<td>79 must be utilized.</td>
</tr>
</tbody>
</table>

### Impact of Payment of Surgical Modifiers

The primary and main concern of failure to use the appropriate and necessary surgical modifiers is complete denial of the 2nd procedure, as ‘inclusive’ as it may be automatically denied, due to being in the global period. Based on the procedure completed, this can be quite costly:

- Appeals and resubmissions are expensive to any organization; as failure to capture the right information the first time is the most effective and efficient ‘cleans claim’ billing process.
Splitting the Global Surgical Package

54
- Surgical Care ONLY
- To identify that a provider ONLY did the surgery, that someone else will be billing the post-op care (OPHTH-OPTOMETRY for 'comanaged cataract patients)

55
- Post-op Management ONLY
- Physicians can SHARE the post-op care as well
- Reported with procedure code, original date of surgery, NOT the date the patient was seen

56
- Pre-op Management ONLY

Example of Splitting the Global Package

Let’s split the global package of the extracapsular cataract surgery; 66984 (allowable $742.38)

66984-56 Pre-operative service provided by the ophthalmologist doing the pre-operative work-up ($74.24)
66984-54 Surgery only, by the ophthalmologist performing surgery ($519.67)
66984-55 Post-op follow-up, provided by the optometrist that the ophthalmologist referred patient to, for follow up and glasses ($148.48)
Multiple/Bilateral Procedures

Modifier 51
- Modifier ONLY recognizes that it is a multiple procedure
- Is NOT a pricing modifier, although many payers reduce reimbursement for multiple procedures. 100% paid for the highest physician fee schedule amount and 50% of the fee schedule for each additional procedure.
  - MANY payers do not require this modifier; Medicare no longer requires it. In some areas, claims will be denied if the modifier is utilized.

Modifier 50
- Bilateral modifier, to indicate that the EXACT same procedure was performed on both sides of the body.
- Only appropriate for those areas, where you have ‘two’
  - Bilateral knee replacement
  - Also, NOT a pricing modifier
    - Expected reimbursement is 150% but this is based on multiple procedure reduction rules
    - Some payers would rather have RT and LT on separate line items

Additional Work or Discontinued

Modifier 22
- When a procedure/service took more work, more time, or was unusual from what was expected
- May charge more, when modifier is used
- May not be reimbursed more by payers
- Will expect documentation

Modifier 53
- Discontinued procedure, when a procedure HAD to be stopped, due to the condition of the patient. Still bill the code of the procedure that was being attempted.
Reduced Services
from Code Description

Modifier 52

– Reduced services
– If for some reason, the entire service was not provided, but only a portion of it, this modifier may be used
– Physician should determine how much of the procedure/service was done, and how much the fee should be reduced
– NOT TO BE USED JUST TO REDUCE THE FEE

Example: If a pure tone audiometry, air, CPT® 92552 is performed only on the left ear, modifier 52 should be appended (92552-52). This procedure is a bilateral procedure and was reduced because it was only performed on one ear.

Physician Identifier

AI: Physician of record

This modifier became necessary for Medicare when consultation codes become non-reimbursable to distinguish the attending
Example of AI Modifier

A patient presents to the ER and their CHF is completely out of control; there is a high level of fluid build-up and patient is short of breath.

- The Hospitalist comes to assume care of the patient in the ER and admits the patient
- The Hospitalist then calls in the Cardiologist
  - Both the Hospitalist and the Cardiologist report a 99223 initial hospital service
    - The Hospitalist claim should also include the AI modifier, captured as 99223-AI, which distinguishes that the Hospitalist is the primary physician and the physician of record.

Physical Status

Anesthesiologists must capture the ‘status’ of the patient which identifies the risk of putting the patient to sleep

- **P1** Normal healthy patient
- **P2** Patient with mild systemic disease
- **P3** Patient with severe systemic disease
- **P4** Patient with severe systemic disease that is a constant threat to life
- **P5** A moribund patient who is not expected to survive without the operation
- **P6** A declared brain-dead patient whose organs are being removed for donor purposes
  - Helps clearly identify the risk; also some payers increase the base units based on the risk, so may impact payment
Anesthesia

Modifier 23

If a procedure that does not usually require anesthesia, but because of circumstance requires general anesthesia; this modifier should be utilized

Record must clearly indicate why general anesthesia was required

Example: A cystoscopy does not usually require general anesthetic. However, if performed on a young child who can not be controlled, general anesthetic may be necessary. Append modifier 23 in this case.

Repeats

Modifier 91

- FOR use on REPEAT LAB TESTS, ONLY.
- If the exact same test is done, on the same date, because they want to compare data, this is appropriate.

Modifier 76

- Repeat procedure by same doctor, same date.
- Chest X-ray done at 10 am, 1 pm, and 3 pm.
- Modifiers needed on the 1 pm and 3 pm service.

Modifier 77

- Repeat procedure by different doctor, same date.
- Works just like the 76 modifier, but identifies that it is a different physician.
Payment Impact and Use of ‘Repeat Modifiers’

- Patient presents to the office and two nebulizer treatments are given to try to get the pulse oximetry measurement to be satisfactory, due to a severe asthma attack
  - The second nebulizer would be reported with a modifier 76
- An inpatient has two EKGs during the same hospital day, as first shows abnormalities; and separate Cardiologists read the two tracings; 93010 would be reported by the first and 93010-77 would be reported for the second cardiologists reading
- A blood glucose was taken in the morning and was repeated every 4 hours throughout the day; to insure that the glucose levels were stabilizing
  - Each repeat lab would be submitted with modifier 91
- Why? Impact without?
  - It is important to identify to the payer that these are ‘repeat’ services, so that each service is separately reimbursable
  - Failure to utilize the modifiers can result in claims being denied as duplicate procedures

CLIA Waived

**QW** CLIA waived laboratory service

Should be attached to most CLIA waived services when POS testing done in the office that has a CLIA waived certificate

- Some CLIA waived tests do not require the modifier
  - CMS publishes an active list of those tests considered CLIA waived and which require the modifier
Assists

80 Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

81 Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

82 The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s)

AS Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery

Assistant does not need to dictate a separate operative report, but operative report of primary must capture the medical necessity of the assistant and the role the assistant played in the surgery. Cannot just show ‘assisted by’ in the header and use terms like ‘we’ and ‘us.’

Assistant Reimbursement Impact

• While reimbursement for assistants at surgery may change somewhat by payer; if a physician is providing the assistant, the CMS allowable is 16% of the allowable for the procedure
• Reimbursement changes, when an AS is used to identify that the assistant is a mid-level provider and is at 13% of the allowable for the procedure
• When an 82 modifier is utilized, it is reimbursed the same as when the 80 modifier is used, at a rate of 16%; however, this modifier differs in that it allows for payment in a teaching facility for an assistant. When a qualified resident is available, no separate reimbursement is allowed
  – If the modifiers are not utilized appropriately and the code is reported by both the primary and the assistant; a duplicate denial will occur
  – If a duplicate denial does not occur; and full fee happens to be paid for both the primary and the assistant; an overpayment has been made and a refund is required

Regence in Oregon for example: reimburses at 20% for the 80 and 82 and 10% for the AS and the 81: http://www.or.regence.com/provider/library/policies/reimbursement-policies/modifiers/modifier-80-81-82-and-as-assistant-at-surgery.html

Medicare rarely pays for modifier 81/Minimal assist
Co-Surgeons

Co-surgery should only be reported when 2 surgeons work together on the same procedure and each provides distinct parts; where the surgery for each would have to be reported with the same CPT® code.

- If surgeons perform surgery together, but each does a uniquely identified procedure; they each would report their own procedure code
  - Based on the CMS National Physician Schedule Relative Value File; the values include

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Co-surgeon not permitted</td>
</tr>
<tr>
<td>1</td>
<td>Co-surgeons may be paid; supporting documentation required to establish medical necessity</td>
</tr>
<tr>
<td>2</td>
<td>Co-surgeons permitted; no documentation required if 2 specialty requirements met</td>
</tr>
<tr>
<td>9</td>
<td>Co-surgeon concept does not apply</td>
</tr>
</tbody>
</table>

Co-Surgeon Reimbursement

- When utilized, both surgeons have to be completing a primary portion of the same surgical code
  - Reimbursement would be based at 125% of the allowable, with each physician receiving 62.5% of the allowable
  - When the Value is a 0 or a 9, it is never appropriate to utilize modifier 62
New Modifiers as Things Change

**33** The US Preventive Services Task Force as part of the evidence based service created the need for a modifier 33 to be utilized when reporting a service that the intent was preventive in nature.

- If the code description already identifies it is a preventive service, this modifier is not necessary.

More on Modifier 33

While this modifier is not in the CPT® book, it was announced in April of 2011 and made retroactive to January 2011.

- If a screening colonoscopy is being provided (to a non-Medicare patient) and CPT® code 45378 would be appropriate, but during colonoscopy a polypectomy was performed and CPT® 45383 was actually completed; the modifier 33 is necessary to show that it started as a screening service.
  - While modifier 33 does not have an impact on the allowable amount; it has a significant impact on the patient responsibility, as preventive services, based on the new piece of legislation have no cost-share.
Mandated Services

32 This modifier should be attached when the service is mandated by a third party: legal, insurance company, etc.

- Since the disinvestment of confirmatory consults, when insurance needs a second opinion, on occasion this modifier must be utilized to capture the service was mandated.

Example of Modifier 32

- A cardiologist determines that a patient needs a mitral valve replacement for a mitral valve prolapse; however, the patient has had this condition for several years.
- The insurance company does cover mitral valve repair, but requires a second surgical consultation prior to surgery.
  - The cardiologist providing the second opinion, should report his service with a modifier 32 to show that it was mandated by the insurance company
  - Failure to report the modifier can result in a denial, based on not medically necessary; as another physician has already provided this service
    - This alerts the insurance company that this was a requirement of their policy and the service should be covered
Why ‘G’??

**GA** Waiver of liability statement issued as required by payer policy, individual case
Should be used only when a properly executed ABN is completed for the service

**GZ** Item or service expected to be denied as not reasonable and necessary
Utilized for those services in which an ABN should have been obtained, the service is expected to be denied, but an ABN was not garnered

**GY** Item or service statutorily excluded, does not meet the definition of any Medicare benefit or for non-Medicare insurers, is not a contract benefit

Examples of GA, GY, GZ, and Impact to Reimbursement

Medicare reimburses for a screening colonoscopy in a high risk patient every 23 months. A patient chooses to have this service every year. It is explained to the patient that it will be outside the frequency parameters and will not be covered every year and if denied, the patient would be responsible and an appropriate ABN is executed.

- A GA modifier is attached to the colonoscopy code, which alerts Medicare that it is expected to be denied as not reasonable and necessary and that the patient was informed.
  - CRITICAL to denial, as when the GA is attached, the service will be denied as ‘patient responsibility’ instead of ‘not medically necessary’
  - If denied as not medically necessary, the service cannot be balance billed to the patient, resulting in lost revenue to the organization.
GA,GY, GZ continued…

• In the colonoscopy example, where the service is outside the frequency parameters, but no ABN was obtained, a GZ modifier should be attached
  – While this is a modifier you do not wish to utilize; as it implies you know the service may not be covered, you do not have an ABN; and expect a denial. LOST REIMBURSEMENT, when a denial is received, patient cannot be billed because no ABN was obtained

• Some services are never covered, when this occurs, an ABN is not necessary, but the claim also should not be billed to CMS; however, if a denial is needed and wanted, it can be filed and a modifier GY should be attached. This clearly tells CMS that you know the service is statutorily excluded and will not be covered.
  – Patient can be balance billed or can be filed with a secondary policy if one exists

G…I don’t know

GG Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day
Done as completely separate services, but on the same day, as a direct result of Radiologist findings
Both services will be covered

GH Diagnostic mammogram converted from screening mammogram on same day
Done at one setting and the plans changed based on Radiology determination
• Only diagnostic mammogram will be covered
E/M Modifiers

Modifier 25
- Very common modifier
- For use on an E/M code ONLY
- Identifies that the E/M service is separate and significant from any other service provided on that date
- Documentation MUST support
  - DO NOT have to have a different diagnosis
  - DO HAVE to show that it was separate and significant

Example of Modifier 25
- Patient presents to the office for upper respiratory symptoms, and following chest X-ray a pneumonia is identified. During the course of the examination, a suspicious lesion is identified on the back and it is recommended that a biopsy be taken, which is done during the visit. The E/M service was separate and significant from the biopsy.
  - Modifier 25 must be attached to the E/M service
  - The diagnoses should be linked appropriately with the upper respiratory symptoms or definitive diagnosis if determined with the visit and the unspecified skin lesion for the biopsy
  - If the modifier 25 is not attached to the E/M service, often the visit will be denied as included or bundled in the procedure
  - Financial impact can be lost revenue of the E/M service, based on the level of service medically necessary and supported
    - Let’s say, that based on the medical necessity of the visit and the final diagnosis of pneumonia a level four service was supported and no modifier was used, the potential lost reimbursement could be about $75.00 per visit
      - Easy to see, that if failure to use this modifier, over time and frequent occurrences, could have an impact to a physician’s practice financially
E/M Modifier

Modifier 24

- For use on an E/M service, when it is provided during the ‘global surgical package,’ but is unrelated

  • Patient had knee surgery. Total Knee Replacement has 90 day global period. During 90 days, sprained ankle. Modifier 24 needs to be attached on the office visit to show it was NOT related and not part of the global surgical package

Reimbursement Impact of Modifier 24

• If the modifier 24 is not attached to the E/M service, the E/M service will be denied as ‘inclusive in the global package’

• The financial impact to the organization would be determined by the level of service which had been reported, as medically necessary and supported
  
  – Lets say that the sprained ankle was of low complexity and a 99213 was reported; this would be potential lost revenue of about $50.00
E/M Modifier

Modifier 57
– For use when an E/M service is within 24 - 48 hours of a MAJOR SURGICAL procedure, but was the visit when it was determined that surgery was necessary

• Patient with severe abdominal pain, was sent to General Surgery for evaluation. During the visit, the surgeon determined that the patient needed surgery immediately and it was scheduled for later that same day. Modifier 57 needed on the visit, or it will be included in the ‘global surgical package’

Reimbursement Impact of Modifier 57

• If the E/M when the initial decision to perform surgery is submitted without modifier 57; it will be considered ‘inclusive to the global package’ and not separately reimbursable
  – The impact of total dollars would be based on the type of E/M service involved and the level of service involved
    • For example, if this visit occurred as a level four ER visit, lots revenue would be about $115; if this visit was a level three hospital admission, it might be $194 in lost revenue
Risky Modifier

Modifier 59
- Modifier of LAST RESORT
- Only use if an anatomical modifier can not clearly identify that it was separate and significant
- NOT just to be attached to bypass an edit
- Must be DISTINCT AND SEPARATE (separate incision, separate excision, separate time of day, etc)
- MUST be supported by chart documentation


Modifier 59 continued

- Do not use modifier 59 if there is a more appropriate modifier
- Review NCCI edits for Medicare and payers who use CCI Edits
  http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEditing/list.asp#
  TopOfPage
  - Status indicator “0” cannot be submitted separately. Modifier 59 can not be used, no exceptions
  - Status indicator “1” can submit modifier if supported by the documentation.
  - Status indicator “9” not subject to CCI edits
## NCCI Example

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<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Effective Date</th>
<th>Deletion Date</th>
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<td>20090401</td>
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<td>9</td>
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<td>*</td>
<td>1</td>
</tr>
</tbody>
</table>

## Workbook Exercises
Thank You

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