

Why Modifiers Are More Necessary Than Ever Before

Qualifying codes before submitting claims can prevent them from bouncing back and improve an office's efficiency.

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Modifiers help to ensure the submission of clean claims to insurance companies. Appending a modifier to the appropriate current procedural terminology (CPT) or healthcare common procedure coding system (HCPCS) code conveys specific information to a payer and indicates that the submitted service or procedure includes special payment or informational circumstances.

This article describes common modifiers, clarifies their use, and identifies potential conflicts that could result in a claim's rejection.

EVALUATION AND MANAGEMENT SERVICE MODIFIERS

Appending an evaluation and management (E/M) service modifier to a CPT or an HCPCS code indicates the purpose of the visit or procedure (Table 1). For example, the *CPT Manual* designates modifier -25 as a "significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service of the encounter." Modifier -25 should be appended to an E/M service that is billed with a procedure (with a zero- to 10-day global period). In contrast, modifier -57 (decision for surgery) should be used with an E/M service that is billed on the day before or the day of a major surgery (with a 90-day global period). Physicians should attach these modifiers to the E/M code when another service is performed on the same day and a significant, separately identifiable E/M service is provided above and beyond the usual preoperative and postoperative care associated with the procedure (-25) or surgery (-57). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. Therefore, different diagnoses are not required

for reporting the E/M services on the same date.

The payment for modifier -25 can and does vary among payers. Some bundle an E/M service on the day of the procedure/service into the payment for the procedure/service, but others deny the E/M service while allowing the payment for the procedure/service.

Unlike modifiers -25 and -57, which are associated with payment, modifier -24 (unrelated E/M service by the same physician during a postoperative period) is informational. This modifier should be added to an E/M code to indicate that the physician performed the submitted service during a postoperative period for a reason(s) unrelated to the original procedure.

USING MODIFIERS TO FINE-TUNE CLAIMS

Anatomic Modifiers

To report bilateral procedures that are performed during the same operative session, physicians should append the modifier -50 to the appropriate CPT or HCPCS code. This modifier is appropriate for any procedural code that is not automatically identified as "bilateral" and is to be reported on a single line item with one unit of service.

If a bilateral procedure is submitted with two lines, use the -LT (left) and -RT (right) modifiers with the first and second procedural codes, respectively, to indicate the side of the body on which the procedure was performed.

The reimbursement for bilateral surgeries—whether or not they are submitted with the -50 or LT/RT modifiers—is normally 150% of the allowed amount for the same procedure performed unilaterally (Table 1).

Modifiers for Professional and Technical Components

Certain procedures, including diagnostic tests, combine professional and technical components that can be

TABLE 1. COMMON MODIFIERS FOR CPT AND HCPCS CODES

E/M Service Modifiers		
25	Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service	P*
57	Decision for surgery	P
24	Unrelated E/M service by the same physician during a postoperative period	†
Anatomic Modifiers		
50	Bilateral procedure	P
LT	Left side (procedure performed on the left side of the body)	P
RT	Right side (procedure performed on the right side of the body)	P
Professional and Technical Component Modifiers		
26	Professional component	P
TC	Technical component	P
Procedural and Surgical Modifiers		
51	Multiple services	P
22	Unusual procedural service	P
47	Anesthesia by surgeon	P
52	Reduced services	P
53	Discontinued procedure	P
58	Staged or related procedure or service by the same physician during the postoperative period	P
59	Distinct procedural service	P
76	Repeat procedure or service by same physician	P
78	Unplanned return to the operating/procedural room by the same physician following initial procedure for a related procedure during the postoperative period	P
79	Unrelated procedure or service by the same physician during the postoperative period	P
Dual Management and Split Care Modifiers		
54	Surgical care only	P
55	Postoperative management only	P
56	Preoperative management only	P
62	Two surgeons	P
77	Repeat procedure by another physician	P
80	Assistant surgeon	P
82	Assistant surgeon (when qualified resident surgeon not available)	P
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	P
Informational Modifiers		
GA	Waiver of liability statement on file	I
GY	Statutorily excluded from Medicare program	I
GZ	Item or service expected to be denied as not reasonable and necessary	I
*Special payment circumstances. †Special informational circumstances.		

reported separately to payers for reimbursement. For example, the addition of modifier -26 (professional component) to a procedural code indicates that the physician should be paid for his interpretation. Submitting the same code with the modifier -TC should trigger a payment for technical charges only. Medicare normally reimburses providers 40% and 60% of the scheduled fee for a procedure's professional and technical components, respectively.

Procedural and Surgical Modifiers

If a physician performs multiple procedures during a single session, he may request payment for services that are not included in the primary code by appending modifier -51 to the code(s) for the additional procedure(s). Modifier -51 should not be applied to E/M services or physical medicine and rehabilitation services performed at the time of the primary procedure. Nor is it appropriate for the provision of supplies (eg, vaccines) at the time of the primary procedure. It should also not be appended to designated add-on codes such as 66990 (use of ophthalmic endoscope). When multiple procedures are submitted with the -51 modifier, Medicare reimburses the physician 100% for the first procedure listed and 50% of the allowed fee schedule for the second through fifth procedures.

Several modifiers allow physicians to request reimbursement for special circumstances they encounter during routine procedures (Table 1). For example, adding modifier -22 (unusual procedural service) to a procedural code indicates that the work required to complete the indicated procedure was substantially greater than normal. Claims submitted with modifier -22 must include documentation that substantiates the circumstances that increased the physician's intraoperative workload (ie, greater intensity, extended surgical time, increased technical difficulty, greater severity of the patient's condition, additional physical and mental effort). Physicians should note, however, that modifier -22 should not be used with an E/M code.

Surgeons may report the administration of regional anesthesia during a procedure by adding modifier -47 to the procedural code for the basic service. This modifier does not include topical anesthesia, and it should not be used in conjunction with dedicated anesthesia codes.

If a physician is unable to complete a procedure or treatment he has already started, he may indicate the reduced level of service (modifier -52) or the complete discontinuation of a procedure (modifier -53) by appending the appropriate modifier to the submitted procedural code. Modifier -53 is most often associated with extenuating circumstances that threaten a patient's

well-being intraoperatively. It should not be used to report the elective cancellation of a procedure prior to the patient's induction to anesthesia or his preparation for surgery in the OR. Outpatient hospitals or ambulatory surgical centers that want to report the partial reduction or complete cancellation of a previously scheduled procedure should append modifier -73 (discontinued outpatient procedure prior to anesthesia administration) or -74 (discontinued outpatient procedure after anesthesia administration) to the appropriate procedural code.

"Physicians should remember that -59 is the modifier of last resort, and it should be used only if no other modifier is appropriate."

The addition of modifier -58 (staged or related procedure or service by the same physician during the postoperative period) to a procedural code indicates that the physician anticipated performing (1) another (staged) procedure, (2) a more extensive procedure, or (3) additional therapy during the original procedure's postoperative period. He may report these circumstances by adding modifier -58 to the codes for the staged or related procedure.

Alternatively, modifier -59 may be used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. The qualifying criteria for -59 include:

- different sessions;
- different procedures or surgeries;
- different anatomic sites or organ systems;
- separate incisions or excisions;
- separate lesions; and
- separate injuries or areas of injuries (in extensive injuries).

Physicians should remember that -59 is the modifier of last resort, and it should be used only if no other modifier is appropriate. They should be especially careful when using modifier -59 (or any other modifier) to break Medicare's Correct Coding Initiative policy's bundling edits. The policy's narratives define the appropriate use of modifiers for unbundling coding pairs, and it warns physicians that they should not seek payments from patients for services that were denied due to the Correct Coding Initiative edits.

Surgeons can improve their chances of payment for procedures performed during a previous surgery's post-

operative period by submitting their claims with the proper modifier.

For example, adding modifier -76 to the repeated procedural code indicates that the surgeon performed the same procedure on the same patient. Modifier -78, however, indicates that the patient was taken back to the OR during the original surgery's postoperative period to address a complication that was related to the original procedure. The payment for a procedure modified by -78 is based on the percentage of the original procedure's total global fee and differs depending on the original procedure. Finally, if a physician performs a procedure or service during the postoperative period that is unrelated to the original procedure, he should append modifier -79 to the code he submits for the second procedure.

MODIFIERS FOR DUAL MANAGEMENT AND SPLIT CARE

Managerial modifiers are useful for securing payment when multiple physicians, nurse practitioners, or clinical nurse specialists comanage the same patient. When different physicians furnish parts of a global surgery package, the total global reimbursement is divided among participating healthcare providers (Table 1). Typically, all of the physicians involved in a single patient's surgical care should submit the same procedural code with different modifiers. For example, the physician who performed the actual procedure would use modifier -54. Physicians who exclusively provided postoperative (modifier -55) or preoperative (modifier -56) services would indicate their role in the patient's surgery by appending the appropriate modifier to the proper procedural code.

To ensure that their claims are processed properly, providers should include the date of surgery in the "from/to" area of the claim line for all procedures modified by -54 or -55. In addition, they should indicate the dates when the care was assumed and relinquished in item 19 of the CMS-1500. Modifiers -54 and -55, however, should be billed only for procedural codes that have global periods of 10 to 90 days.

When physicians simultaneously serve as primary surgeons and perform distinct parts of the same procedure, each should indicate his contribution to the operation by adding modifier -62 to the primary procedure's code and any associated add-on code(s). Each surgeon should report the surgery once using the same procedural code. If the surgeons perform additional procedures during the same surgical session, they may append modifier -62 to the appropriate codes before submitting their claim to their payer. Medicare divides the payment for comanaged surgery (typically 125% of

the scheduled fee) equally between the participating physicians.

Additional modifiers that provide payment information about procedures include -77 (the repetition of a basic procedure or service that was previously performed by another physician), -80 (indicates services provided by an assistant surgeon), -82 (the participation of an assistant surgeon when a qualified resident was not available), and -AS (indicates surgical assistance from a physician's assistant, nurse practitioner, or clinical nurse specialist).

INFORMATIONAL MODIFIERS

The addition of an informational modifier to a procedural code gives the payer further information related to the payment of the claim (Table 1). If a physician performs a procedure or service that Medicare might deem unreasonable or medically unnecessary, he should append modifier -GA (waiver of liability statement on file) to the appropriate procedural code. This modifier indicates that the patient was notified in advance that Medicare might refuse to pay for the procedure and that he might be responsible for its cost.

Physicians should use modifier -GY (statutorily excluded from Medicare program) when they submit a code for a service that they know is never covered by Medicare. Their offices may then collect the cost of the service directly from the patient without first billing Medicare. Finally, the addition of modifier -GZ to a procedural code shows that the physician expects Medicare to deny the modified service as unreasonable and unnecessary. Unlike with modifier -GA, however, the physician failed to obtain an Advanced Beneficiary Notice and therefore knows he cannot bill the patient for the service after the claim is rejected.

It is important to remember that modifiers -GA, -GY, and -GZ may not be used together (the use of one mutually excludes the use of the other two).

CONCLUSION

Clinicians should not wait until their insurance companies deny their claims to start using the correct modifiers. They should instead educate their staff to accurately capture this information on patients' encounter forms before they submit their final claims. Physicians can streamline this process by listing the most useful modifiers on their encounter forms and by optimizing their billing software to produce clean, accurate claims that facilitate speedy reimbursement. □

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