Using Modifiers Wisely

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What is a modifier?
A modifier indicates that a service or visit was altered in some way from the stated CPT descriptor without changing the definition. In other words, something else happened during the visit that was out of the ordinary. Normally when you use more than one procedure, you want to explain why the additional procedure was performed. If only one procedure was performed and something was out of the ordinary, such as the procedure was terminated, there was more than one surgeon, etc., then a modifier is to be used with the single procedure.

MODIFIER 21:
Prolonged evaluation and management service. In 2009, (Modifier 21 was deleted. To report prolonged physician services, see 99354-99357)

MODIFIER 22:
Modifier 22 produces an automatic review or audit by payers, so supporting documentation must be attached to the claim. In addition, don't expect modifier 22 to be honored for extra payment if it is used too frequently—remember it is to be used for unusual services only. If approved, payment for 22 may be an additional 20%–50% of the allowable rate for the procedure performed. This modifier is used and appended to procedures only, and not Evaluation and Management services. Examples for use of this modifier are multiple deliveries, unusual bleeding, significant scarring, or adhesions.

MODIFIER 23:
Under unusual circumstances, general anesthesia may be performed for procedures that typically require local or regional anesthesia or no anesthesia at all. The modifier "23" should be submitted with the appropriate procedure code to report unusual anesthesia. This modifier should not be reported with procedure codes that include the term "without anesthesia" in the description or for procedures that are normally performed under general anesthesia. The payer will review unusual anesthesia claim submissions on an individual consideration basis and will provide payment for medically necessary services. Documentation to support the reported service must be provided with the claim.

MODIFIER 24:
Each CPT code has a global period that varies from zero to 90 days (some carriers have longer global periods, e.g., 120 days). If the provider is seeing a patient in the office following a procedure that has a global period and the patient has a new diagnosis that is unrelated to the procedure, the 24 modifier will protect the service from being bundled into the global surgical package, and reimbursement should be permitted. A different diagnosis code (ICD) is required, and it must be linked. Supporting documentation must be submitted when the visit is unrelated to the surgery. The supporting documentation can be in the form of an ICD-9-CM code and/or documentation in the electronic documentation record or as an attachment to the CMS-1500 claim form. This modifier should be added to the E&M Code.

MODIFIER 25:
Modifier 25 is used to describe significant, separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service or procedures rendered during the same visit. Always attach the modifier to the evaluation and management code. The same diagnosis code can be used to support an E/M and the additional procedure. Some examples of separate and distinctly identifiable services are:

Initial hospital visit, initial inpatient consultation or hospital discharge and an inpatient dialysis service. Modifier 25 would be appropriate on the E&M code.

Unscheduled E&M service performed the same day as a preventive exam-when the service is in addition to the preventive care.

MODIFIER 26 AND TC

CPT modifier -26 represents the professional (physician) component of a service or procedure and includes the physician work, associated overhead and professional liability insurance costs. This modifier corresponds to the human involvement of a given service or procedure. HCPCS Level II modifier -TC represents the technical component of a service or procedure and includes the cost of equipment and supplies to perform that service or procedure. This modifier corresponds to the equipment/facility part of a given service or procedure. In most cases, unmodified codes represent a complete/global service or procedure which includes both the professional and technical components. There are procedures that cannot be separated into professional and technical components. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Neither CPT modifier 26 nor HCPCS modifier TC can be submitted with these codes. Modifier 26 or TC can be reported as follows:

Diagnostic tests or radiology services, for example pulmonary function tests, or therapeutic radiology procedures generally have both a professional and technical component modifier 26 and TC may be submitted with these codes.

Professional component only codes describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is CPT code 93010: Electrocardiogram; interpretation and report. Neither CPT modifier 26 nor HCPCS modifier TC can be submitted with these codes.

Technical component only codes identifies stand-alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic test only. An example of a technical component only code is CPT code 93005: Electrocardiogram; tracing only, without interpretation and report.

Incident to codes describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician or working under his or her direct supervision. Payment is not normally made for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Neither CPT modifier 26 nor HCPCS modifier TC can be submitted with these codes.

Physician interpretation, using modifier 26 identifies the professional component of clinical laboratory codes for which separate payment may only be made if the physician interprets a laboratory test and did not perform the test within the office or practice. No technical component submission is recognized because payment for the underlying clinical laboratory test is made to the hospital or outside laboratory.

MODIFIER 32:

The use of modifier -32 does not force a payer to provide benefits that are not included in the benefit plan. Modifier -32 is intended to report services such as consultations for a second opinion required by a payer prior to a patient receiving a service. Use modifier -32 in addition to an Evaluation and Management (E/M) code to identify an initial/comprehensive office visit for the purpose of an injury assessment and in-depth evaluation of medical complaint(s) and present injury, past medical history, system review, physical examination, ordering of appropriate tests and procedures, and the preparation of an appropriate. If a confirmatory consultation is required, eg, by a third party payor, the modifier '-32', mandated services, should also be reported.

MODIFIER 47:
Reimbursement for administration of regional or general anesthesia provided by surgeons is included in the reimbursement for the surgical or other procedure and is not separately reimbursed. However, a surgeon providing these services may report administration of
regional or general anesthesia by appending modifier 47 (Anesthesia by Surgeon) to the CPT code for the surgical or other procedure. Inappropriate use of modifier 47 includes:
_ Billing the surgical or other procedure on one line item and the surgical or other
procedure with modifier 47 on a separate line item.
_ Billing modifier 47 with ASA codes 00100-02020.
_ Billing modifier 47 to report administration of local anesthetic.
Inappropriate use of modifier 47 may result in the rejection/return of claim, delay in
reimbursement, and/or incorrect reimbursement. Overpayments resulting from inappropriate use of modifier 47 may be subject to recovery. Under Medicare's payment policy, separate reimbursement for a local, regional, or digital block or general anesthesia administered by the surgeon is not allowed. When the surgeon performs these services, Medicare's payment for the anesthesia service is considered included in the resource based relative value scale (RBRVS) payment for the procedure.

MODIFIER 50:
Modifier 50 may be used with diagnostic and radiology procedures as well as with surgical procedures. Modifier 50 is used to report bilateral procedures that are performed at the same operative session. Do not use modifiers LT and RT when the modifier 50 applies. With many commercial insurances, if a bilateral procedure is eligible for bilateral reimbursement, enter the bilateral procedure code with modifier 50 on one line with one (1) unit of service. When services are provided in a freestanding or an outpatient hospital ambulatory surgical center, a bilateral procedure is eligible for bilateral reimbursement. The procedure code is reported on two lines. The first line contains the procedure code with no modifier. The second line contains the procedure code with modifier 50. For example, Jim had an Endoscopic Maxillary antrostomy with removal of sinus contents, right and left. The procedure code should be reported on two lines with modifier 50 on the second procedure or line. The claim would be coded as follows:

31267
31267-50

With Medicare. , if a bilateral procedure is eligible for bilateral reimbursement, enter the bilateral procedure code with modifier 50 on one line with one (1) unit of service. Some insurance companies may want you to submit the claim with the surgery on a single detail line with CPT modifier 50 and a quantity of "1." Or with an option to submit the surgery on 2 detail lines, one with HCPCS modifier RT and one with HCPCS modifier LT. Always check carrier requirements when using Modifier -50.

MODIFIER 51:
Modifier 51 is defined by CPT as Multiple Procedures: When multiple procedures, other than Evaluation and Management services are performed at the same session by the same provider, 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). In the case of modifier –51, what you are telling the payor is that you did two procedures in the same operative session. You can append it to services but don't expect it to effect whether or not the service gets paid. There are some exceptions to any rule: Medicare does NOT want you to use this modifier at all. They append it during processing to indicate if a service was subject to a multiple surgery reduction. Some smaller insurance companies such as a workers comp payor may require the use of this modifier so you will need to check with those. All other payors don't adjudicate payment based on modifier –51. Medicare does require that providers list the major procedure first in order for multiple procedures to reimburse correctly. Submit the major procedure on line one and complete the claim form by listing the second through fifth procedures on the subsequent lines. Insurances usually reimburse multiple procedures with the 1st major procedure at 100% of the allowed fee. The second procedure is reimbursed at 50% of the allowed fee. The 3rd through 5th procedure is reimbursed at 25% of the allowed fee.

MODIFIER 52:
Use CPT modifier 52, Reduced Services, with a service or procedure that is partially reduced or eliminated at the physician's discretion. This is a way of reporting reduced services without disturbing the identification of the basic service. Code to the extent of the procedure performed; if you completed a portion of the intended procedure and a code exists that represents the completed portion, use that code. For example, do not code services described as "complex" with modifier 52 if codes exist for "intermediate" and "simple." Similarly, don't code procedures or services described as bilateral with modifier 52 to indicate a reduced, unilateral service if a "unilateral" code exists. If no code exists for the procedure as you performed it, report the intended code with modifier 52. Do not bill for an evaluation and management service using modifier 52. Medicare — and mostly likely all payers — do not recognize modifier 52 for this purpose. When you bill using modifier 52, be sure to include a statement explaining the reduction of the service or procedure. For example, Medicare requires you to submit an operative report (for surgical procedures) or other appropriate documentation (for nonsurgical services) AND a statement how the reduced service or procedure differs from the standard. Without this statement, Medicare will deny the code billed with modifier 52. An example of Modifier 52 would be Radiology service 73120, "Radiologic examination, hand; two views," is started but only one view can be performed. There is no other HCPCS code to describe this service. The x-ray would be billed as: 73120 52.

MODIFIER 53:
If the intended procedure is started but terminated due to extenuating circumstances or those that threaten the well being of the member, attach modifier 53 to the code. Reimbursement will be reduced according to the services performed before the procedure was discontinued and priced to a code that reflects the service performed. Documentation in the form of an operative report is required to make a determination of payment. Do not use this code to report the elective cancellation of the procedure prior to administration of anesthesia and/or surgical preparation of the patient in the operating room suite. When there is no comparable code for establishing reimbursement, Medicare pre-op, post-op and intra-op percentages will be used to determine reimbursement. Modifier -53 is not valid when used for elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. Modifier -53 is not valid when a laparoscopic or endoscopic procedure is converted to an open procedure or when a procedure is changed or converted to a more extensive procedure.

MODIFIER 54:
Submit CPT modifier 54 when one physician performs a surgical procedure and another provides preoperative and/or postoperative management. Submit this modifier with the surgical procedure code. Surgeons performing the major surgery and providing partial follow up care during the global period of a surgery must submit the claim as follows: Submit the surgery with CPT modifier 54 (Surgical care only) on one detail line. On a separate detail line, submit the surgery date as the date of service, the surgery code with CPT modifier 55 (Postoperative management only), and the number of postoperative days the patient was under the surgeon's care (e.g., 30). Refer to CPT modifier 55 for additional instructions regarding postoperative management. The total reimbursement for a surgical procedure is the same regardless of how the billing is split between the different providers involved in the patients care. Correct coding guidelines require that when the components of a global surgical package are performed by different physicians, the same surgical procedure code (with the appropriate modifier) be used by each physician to identify the services provided. The intra-operative and post-operative services should be billed with the date of the surgery as the date of service. A surgeon performing **only** the surgical component of a global surgical package (with another physician providing the postoperative care) **must** attach modifier -54 to the surgical procedure code. A physician providing **only** the postoperative component of a global surgical package (with another physician performing the surgical procedure) **must** attach modifier -55 to the surgical procedure code. An E&M visit code is not appropriate to use in this situation. A physician providing **only** the preoperative evaluation component of a global surgical package (with another physician performing the surgical procedure and postoperative care) **must** attach modifier -56 to the surgical procedure code. An E&M visit code is not appropriate to use in this situation.

MODIFIER 55:
There are occasions when more than one physician provides services included in the global surgical package. It may be the case that the physician who performs the surgical procedure provides only a portion of the follow up care. Payment for the postoperative/post-discharge care is split between two or more physicians when the physician agrees to transfer the postoperative care. When physicians provide only part of the care in the global surgery package, each physician must identify which portion of the package was performed. The use of CPT modifier 54 (surgical care) or 55 (postoperative care) is required. Physicians providing the postoperative care must ensure they submit the same surgical code that was submitted by the surgeon (except add CPT modifier 55 rather than CPT modifier 54). The number of postoperative days the patient was under the surgeon's care (e.g., 30) must be submitted in the appropriate documentation record for electronic claims or in Item 24g of the CMS-1500 claim form for paper claims. The assumed or relinquished postoperative date of care must be indicated in the appropriate documentation record for electronic claims or in Item 19 of the CMS-1500 claim form for paper claims. Failure to submit the documentation appropriately may result in services rejected as unprocessable. Each provider will be reimbursed based on the proportionate percentage of care. When more than one physician furnished services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provided all services (except where stated in policies, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative inpatient care, result in payment that is higher than the global allowed amount).

MODIFIER 56:
CPT modifier -56 represents the preoperative evaluation component of a global surgical package, when performed by a physician other than the surgeon. To bill for pre-operative care without the performance of the surgery, attach a modifier -56 to the procedure code. Some insurance companies will not recognize modifier -56 and in fact, many billed services with modifier -56 will come under review. Modifier -56 can have an effect on payment of the service and may be used on Medicare claims. For an example, a patient presents to his cardiologist for his pre-operative examination and testing. The patient then travels to a cardiothoracic surgeon to have the surgery performed. The patient’s cardiologist will bill for services using modifier -56.

MODIFIER 57:
For Medicare claims, the 57 modifier should be used only in cases in which the decision for surgery was made during the preoperative period of a surgical procedure within a 90-day postoperative period (i.e., major surgery). The preoperative period is defined as the day before and the day of the surgical procedure. Incorrect usage, would be "attaching modifier 57 to the hospital visit code (or office visit code) for the day before surgery or day of surgery when the decision to perform the ‘major’ surgical procedure (as defined by Medicare) was made well in advance of the surgery. Medicare gives reference to issuing payment for the use of modifier 57 as follows: "Pay for an E/M service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses modifier 57 to indicate that the service was for the decision to perform the procedure. Do not pay for an E/M service billed with modifier 57 if it was provided on or the day before a procedure with a 0 or 10 day global surgical period. Carriers are reporting that providers are using this modifier inappropriately to get extra reimbursement for the preoperative clearance evaluation, which is included in the global surgical package. Physicians need to understand that if a procedure has been previously scheduled with the operating team (days or weeks ahead) and the patient now comes in just prior to the procedure for preop clearance, that modifier 57 is not appropriate and can result in an audit.

MODIFIER 58

Staged or Related Procedure or Service by the Same Provider During the Postoperative Period.

Modifier 58 can be used when a *second surgery* is performed in the postoperative period of another surgery when the subsequent procedure was:

- planned prospectively or "staged" at the time of the original procedure; or
- more extensive than the original procedure; or
- for therapy following a diagnostic surgical procedure; or
- for the reapplication of the cast within the 90-day global period.

An example of when to use modifier 58 would be if a patient had a removal of a breast lesion (CPT 19120) followed in less than 90 days by the removal of the entire breast (CPT 19307). Bill CPT 19307-58 for the second procedure. Another postoperative period begins when the second procedure in the series is billed.

MODIFIER 59

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/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 physician. 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." Modifier -59 is an important NCCI-associated modifier that is often used incorrectly.

For the NCCI its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters. It should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes. NCCI edits define when two procedure HCPCS/CPT codes may not be reported together except under special circumstances. If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together if the two procedures are performed at different anatomic sites or different patient encounters. Carrier processing systems utilize NCCI-associated modifiers to allow payment of both codes of an edit. Modifier -59 and other NCCI-associated modifiers should NOT be used to bypass an NCCI edit unless the proper criteria for use of the modifier is met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.

One of the misuses of modifier –59 is related to the portion of the definition of modifier -59 allowing its use to describe "different procedure or surgery". The code descriptors of the two codes of a code pair edit usually represent different procedures or surgeries. The edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter. The provider cannot use modifier –59 for such an edit based on the two codes being different procedures/surgeries. However, if the two procedures/surgeries are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier –59 may be appended to indicate that they are different procedures/surgeries on that date of service. Use of modifier -59 to indicate different procedures/surgeries does not require a different diagnosis for each HCPCS/CPT coded procedure/surgery. Additionally, different diagnoses are not adequate criteria for use of modifier -59.

The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters. From an NCCI perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes a single anatomic site. Treatment of posterior segment structures in the eye constitute a single anatomic site.

Examples:
CPT Code 93015 – Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
CPT Code 93040 – Rhythm ECG, one to three leads; with interpretation and report
Modifier -59 is only appropriate if the rhythm ECG service 93040 is performed unrelated to the cardiovascular stress test procedure at a different patient encounter.

CPT Code 93529 – Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)
CPT Code 76000 – Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)
Modifier -59 is only appropriate if the fluoroscopy service 76000 is performed for a procedure done unrelated to the cardiac catheterization procedure.

CPT Code 97140 – Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
CPT Code 97530 – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
Modifier -59 is only appropriate if the two procedures are performed in distinctly different 15 minute intervals. The two codes cannot be reported together if performed during the same 15 minute time interval.

CPT Code 98942 – Chiropractic manipulative treatment (CMT); spinal, five regions
CPT Code 97112 – Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
Modifier -59 is only appropriate if the physical therapy service 97112 is performed in a different region than the CMT and the provider is eligible to report physical therapy codes under the Medicare program.

MODIFIER 62
Modifier -62 represents two surgeons working together as primary surgeons, performing parts of a surgical procedure or parts of a related surgical procedure, simultaneously. Co-surgeons may be identified when two or more surgeons of the same or different specialties, with or without the same areas of sub-specialization are performing: Parts of a single procedure (identified by a single CPT code). The same or similar procedures in separate body areas (i.e., applying skin grafts to different body areas). Components of related procedures which are generally performed by a single surgeon (ie, one surgeon performs the exposure and/or closure for another surgeon performing anterior spine surgery. Each surgeon working in a team surgery situation, will have their claims processed and charges reimbursement as if they were working as a single surgeon. Prior to surgery, both surgeons must agree to the use of modifier 62. When the providers represent different specialties and different incisions are involved on different organs for different diagnoses most carriers will pay the full allowed amount for each procedure When the providers represent different specialties and different incisions are involved on the same organ for the same diagnosis, the full allowed amount for the procedure with the higher allowed amount and 50 percent for the procedure with the lower allowed amount When the providers represent the same specialty and the same incision is involved on the same organ for the same diagnosis, the full allowed amount for the procedure with the higher allowed amount plus 25 percent of the allowed amount for the same procedure When two surgeons participate in the same surgical procedure and modifier 62 is reported, payers will reimburse 62.5 percent of the surgical allowance to both surgeons. When two surgeons participate in the same surgical procedure and modifier 62 is not reported, payers will reimburse 100 percent of the allowed amount to the first surgeon whose claim is received, and 25 percent to the second surgeon.

MODIFIER 63:
Procedures performed on infants less than 4 kg. This modifier may be submitted with CPT codes 20000-69990. This modifier may ***not*** be submitted with Evaluation and Management, anesthesia, radiology, or pathology/laboratory services or with codes in the CPT "Medicine" section.

MODIFIER 66:
The services of all physician members of a surgical team, including primary and assistant surgeons, must be billed on a single line of one claim form using the appropriate CPT code with modifier 66. EXCEPTION: Anesthesiologists should submit a separate claim using the appropriate five-digit anesthesia procedure code and modifier. Examples of these circumstances include procedures performed during organ transplantation or reimplantation of limbs, extremities or digits. In these instances, the surgeons are not acting as an assistant-at-surgery, but rather as team surgeons. To report as team surgeons, each surgeon participating in the surgical procedure(s) must file a separate claim and append modifier –66 to the specific procedure code(s) used for reporting the services provided. If a surgeon functions as both a team surgeon and an assistant-at surgery for different portions of the total operative procedure, then modifier –66 should be appended to the procedure applicable to team surgery, and modifier –80, -81, or –82, as appropriate, should be appended to the procedure(s) in which the surgeon acted as an assistant. Operative records that clearly demonstrate that each surgeon performed components of a procedure in a team fashion must accompany the claim.
The percentage of the allowed benefit apportioned to each of the team surgeons will be determined based on several factors, including but not limited to:
The complexity of the individual surgical services performed,
The amount of involvement in the operating room,
The amount of pre- and post-operative care required,
Whether the procedures performed are related, incidental, or unrelated to each other.

MODIFIER 76:
Use modifier -76 when a physician performs a service or procedure, and the same physician has to repeat the exact same service or procedure during the global period. This modifier should be used when coding for a repeated procedure on the claim by same physician, same day, however, it does not need to be on the same day, nor is it limited to minor procedures. Use modifier –78. If a separate procedure is preformed during the global period, or in the same visit.

MODIFIER 77:
Modifier -77 is used to indicate that a procedure or service was repeated in a separate operative session on the same day by another physician. If there is a question regarding who the ordering physician was and whether or not the same physician ordered the second procedure, code based on whether or not the physician performing the procedure is the same. The procedure must be the same procedure. It is listed once and then listed again with the appropriate modifier.

MODIFIER 78:
CPT modifier 78: return to the OR for a *related procedure* during the postoperative period
Use when the subsequent procedure is *related* to the first surgery *and* requires the use of an operating room. This modifier may not be submitted when the subsequent procedure does not require the use of an operating room. "Related" refers to the procedures themselves, not to whether they are being performed to treat the same condition. The original postoperative period continues when a subsequent procedure is submitted with CPT modifier 78. ***Example:***
Dr. J performs a double vessel coronary graft (CPT code 33511) on Mrs. P. Subsequent to the procedure, Mrs. P's blood pressure and heart rate drop, and it is determined that she is hemorrhaging. Dr. J takes Mrs. P back to the operating room to locate and stop the hemorrhage.
Submit CPT codes 33511 and 35820-78, because the procedures are related.

MODIFIER 79:
CPT modifier 79: *unrelated procedure* or service by the same physician during the postoperative period Use when the procedure is *unrelated to* the original procedure. CPT modifier 79 may be submitted regardless of whether the procedure required the use of an operating room. "Unrelated" refers to the relationship between the two procedures, not to the reason for which they are performed. A different ICD-9 code must be submitted with the subsequent procedure.
A new post-operative period begins when the subsequent procedure is submitted. ***Example:***
Dr. B performs a total left knee replacement, with patella resurfacing (CPT code 27447), on Mr. W. Two weeks after his total knee replacement, Mr. White slips on the ice on his way to physical therapy and fractures his right wrist. Dr. B operates to repair a Colles' fracture of Mr. W's wrist (CPT code 25620). ***Submit CPT code 27447 with HCPCS modifier LT for the total knee replacement, and CPT code 25620 with CPT modifier 79 and HCPCS modifier RT for open reduction of the Colles' fracture. These procedures are unrelated***.

MODIFIER 80:
CPT modifier -80 represents assistant at surgery by another physician. This assistant at surgery is providing full assistance to the primary surgeon. The assistant at surgery cannot report codes different than the codes reported by the surgeon. An exception to this would be if the surgeon billed a global code (e.g., maternity antepartum, delivery and postpartum). The assistant at surgery would bill the specific surgery code (e.g., delivery only). CMS designates procedure codes eligible for reimbursement for an assistant at surgery. Many payers reimburse assistant at surgery based on the CMS list of procedure codes. Provider Specialties eligible for reimbursement for codes with modifier –80 include MD, DO and DPM. Many payers require copies of medical records (operative notes) to document the medical necessity of an assistant at surgery for codes designated by CMS as requiring documentation. When the procedure submitted is defined as eligible for an assistant, many payers reimburse an average of 20% of allowable. The assistant surgeon classifications assume that the assistant surgeon is board-certified or otherwise highly qualified as a skilled surgeon. Automatic edits are performed on assistant surgeon claims to determine if any procedures have been inappropriately billed by a surgical assistant. If guidelines are not met, the claim will suspend. Documentation must be maintained in the patient's medical record:
A statement that no qualified resident was available to perform the service, or
A statement indicating that exceptional medical circumstances exist, or
A statement indicating the primary surgeon has an across the board policy of never involving residents in the preoperative, operative or postoperative care of his/her patients.

MODIFIER 81
CPT modifier -81 represents minimal assistant at surgery by another physician. This assistant at surgery is providing minimal assistance to the primary surgeon. This modifier is not intended for use by non-physician assistants (e.g., RN, PA). Modifier –AS must be used when the assistant at surgery is a non-physician. CMS designates procedure codes eligible for reimbursement for an assistant at surgery. Many payers reimburse assistant at surgery based on the CMS list of procedure codes. Provider Specialties eligible for modifier –81 include MD, DO and DPM. . This modifier is not intended for use by non-physician assistants (e.g., RN, PA). Many payers require copies of medical records (operative notes) to document the medical necessity of an assistant at surgery for codes designated by CMS as requiring documentation. When the procedure submitted is defined as eligible for an assistant and the assistant surgeon is a physician, it is reimbursed between 10% - 20% of allowable. Documentation must be maintained in the patient's medical record:
A statement that no qualified resident was available to perform the service, or
A statement indicating that exceptional medical circumstances exist, or
A statement indicating the primary surgeon has an across the board policy of never involving residents in the preoperative, operative or postoperative care of his/her patients

MODIFIER 82

CPT modifier -82 represents assistant at surgery by another physician when a qualified resident surgeon is not available to assist the primary surgeon. This modifier is not intended for use by non-physician assistants (e.g., RN, PA). Modifier –AS must be used when the assistant at surgery is a non-physician. The unavailability of a qualified resident surgeon is a prerequisite for submitting CPT modifier 82 with a surgical procedure code. CMS designates procedure codes eligible for reimbursement for an assistant at surgery. Many payers reimburse assistant at surgery based on the CMS list of procedure codes. Provider Specialties eligible for modifier –81 include MD, DO and DPM. . This modifier is not intended for use by non-physician assistants (e.g., RN, PA). Many payers require copies of medical records (operative notes) to document the medical necessity of an assistant at surgery for codes designated by CMS as requiring documentation. When the procedure submitted is defined as eligible for an assistant and the assistant surgeon is a physician it is reimbursed between 10% - 20% of allowable.

MODIFIER 90:

Submit this modifier when laboratory procedures are performed by a person or entity other than the treating or reporting physician. This modifier may ***only*** be submitted with clinical laboratory tests. Independent clinical laboratories may submit this modifier to indicate that the service was referred to an outside laboratory. In general, payment for clinical laboratory tests subject to schedules is only made to the person or entity that performed or supervised the performance of the tests. An exception to this policy allows payment to be made to one independent or hospital laboratory for tests performed by another lab (the referring lab). However, the Omnibus Budget Reconciliation Act of 1989 (OBRA), has amended this exception by restricting payment to referring laboratories. In accordance with S611b of OBRA of 1989, a referring lab can bill for tests performed by a reference lab only if it meets any one of the following three exceptions:
The referring laboratory is located in or is part of a rural hospital;
The referring lab and the reference lab are "subsidiary related." That is:
The referring lab is a wholly owned subsidiary of the reference lab
The referring lab wholly owns the reference lab
Both the referring lab and reference lab are wholly owned subsidiaries of the same entity.
Physicians may not submit claims on behalf of laboratories for tests referred to these laboratories.

MODIFIER 91:

Repeat clinical diagnostic laboratory test. CPT modifier 91 may be submitted to identify an identical laboratory test for the same patient on the same date. This modifier ***may not*** be submitted 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 codes describe a series of test results (e.g., glucose tolerance tests).
For clinical laboratory tests ordered by an ESRD facility: these tests must be submitted with CPT modifier 91 any single service (same CPT code) is ordered for the same patient, and the specimen is collected more than once in a single day, and the service is medically necessary. CPT modifier 91 must be submitted with services that meet these criteria, regardless of whether the test is also submitted with HCPCS modifiers CD, CE, or EF. Any line item on a claim that meets these criteria and is submitted with CPT modifier 91 will be included into the calculation of the 50/50 rule. After calculation of the 50/50 rule, services used to determine the payment amount may not exceed 22.

MODIFIER 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). The test does not require permanent dedicated space; hence by its design it may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

MODIFIER 99:
CPT modifier 99 may be submitted when it is necessary to indicate ***more than 4*** modifiers on a single detail line or service. Although the current CPT manual specifies that CPT modifier 99 may be used when it is necessary to indicate more than 2 modifiers on a single detail line or service, many payers will accept up to 4 modifiers.

MEDICARE MODIFIER GA:
Advance notice has been given to the beneficiary. Submit HCPCS modifier GA when there is a valid Advance Beneficiary Notice (ABN) on file for the service. HCPCS modifier GA ***may not*** be submitted with services that are statutorily excluded. Refer to HCPCS modifier GY for these services.
HCPCS modifier GA does not apply to most ambulance services. For more information regarding ABNs and ambulance services, refer to the CMS Web site:
http://www.cms.hhs.gov/AmbulanceFeeSchedule/downloads/ambabn71603.pdf

MEDICARE MODIFIER GY:
Item or services statutorily excluded or does not meet the definition of any Medicare benefit. Submit HCPCS modifier GY with items or services that are statutorily excluded or those that do not meet the definition of any Medicare benefit. Examples of services for which HCPCS modifier GY may be appropriate include: routine physicals, laboratory tests in absence of signs or symptoms, and hearing aids. You may offer the patient a Notice of Exclusion from Medicare Benefits (NEMB) form. This form is optional. Sample forms are available on the CMS Web site at http://www.cms.hhs.gov/BNI/11_FFSNEMBGeneral.asp#TopOfPage.
You want to use modifier GY 1) When you think a claim will be denied because it is not a Medicare benefit or because Medicare law specifically excludes it. 2) When you think a claim will be denied because the service does not meet all the requirements of the definition of a benefit in Medicare law.
3) When you submit a claim to obtain a Medicare denial for secondary payer purposes. If the claim is denied as an excluded service or for failure to meet the definition of a benefit, the beneficiary will be liable for all charges, whether personally or through other insurance.

MEDICARE MODIFIER GZ;
Medicare created the GZ modifier to indicate that the provider has reason to believe the claim may be denied and that the provider failed to obtain a signed ABN. Despite the availability of the GZ modifier, some providers are still reluctant to use it because they think the modifier will serve as a "red flag" to Medicare. This is not the intended purpose of the GZ modifier. In fact, the CMS website contains instructions on the proper use of the GZ modifier. These instructions state:
"The GZ modifier is provided for physicians and suppliers that wish to submit a claim to Medicare, that know that an ABN should have been signed but was not, and that do not want any risk of allegation of fraud or abuse for claiming services that are not medically necessary."
The above language demonstrates the intended use of the GZ modifier. Simply put, the modifier indicates that the provider thinks the claim will be denied and that it failed to obtain a signed ABN.

MEDICARE MODIFIER Q5:
Services furnished by a substitute physician under a reciprocal billing arrangement. Submit HCPCS modifier Q6 to indicate that services were provided under a Reciprocal Billing Arrangement.
Reciprocal billing background:

On an occasional reciprocal basis, a patient's regular physician will arrange for a substitute physician to provide visit/services, including emergency visits or related services. Under a reciprocal billing arrangement, the patient's regular physician may submit a claim to Medicare Part B using his/her own Provider Identification Number (PIN) or National Provider Identifier (NPI) and, if assignment is accepted, receive payment if the following conditions are met:

The regular physician is unavailable to provide the visit/services;

The Medicare patient has arranged or seeks to receive the visit/services from the regular physician;

The substitute physician does not provide the visit/services to Medicare patients over a continuous period of longer than 60 days; and

The regular physician identifies the services as substitute physician services by using HCPCS modifier Q5 (services furnished by a substitute physician under a reciprocal billing arrangement).

Until further notice, the regular physician must keep on file a record of each service provided by the substitute physician along with the substitute physician's Unique Physician Identification Number (UPIN) or National Provider Identifier (NPI).

If postoperative services are furnished by the substitute physician, the services cannot be submitted with HCPCS modifier Q5 since the regular physician is paid a global fee.
If services are provided by a substitute physician over a continuous period of longer than 60 days, the regular physician must bill the first 60 days with HCPCS modifier Q5 (services furnished by a substitute physician under a reciprocal billing arrangement).
The substitute physician must submit the remainder of the services in his/her own name.
The regular physician may not submit and receive payment for services over the 60-day period.
A new period of covered visit/services can begin after the regular physician has returned to work.

MEDICARE MODIFIER Q6:
Services furnished by a locum tenens physician. Submit HCPCS modifier Q6 to indicate that services were provided under a Locum Tenens Arrangement.
Locum tenens background:

Physicians may retain substitute physicians to take over their professional practices when they are absent for reasons such as illness, pregnancy, vacation, or continuing medical education.
These substitute physicians, known as "locum tenens" physicians, generally have no practice of their own and move from area to area as needed. The regular physician generally pays the substitute physician a fixed per diem amount. The substitute physician's status is that of independent contractor, rather than employee, and his/her services are not restricted just to the physician's office.
Services of nonphysician practitioners (e.g., CRNAs, NPs and PAs) may not be billed under the Locum Tenens or Reciprocal Billing reassignment exceptions. These provisions apply only to physicians.

The regular physician may submit a claim under the locum tenens arrangement using his/her own Provider Identification Number (PIN) or National Provider Identifier (NPI) and, if assignment is taken, receive payment for covered visit services if the following conditions are met:

The regular physician is unavailable to provide the visit/services;

The Medicare patient has arranged or seeks to receive the visit/services from the regular physician;

The regular physician pays the locum tenens physician for his/her services on a per diem or similar fee-for-time basis;

The substitute physician does not provide the visit/services to Medicare patients over a continuous period of longer than 60 days; and

The regular physician identifies the services as substitute physician services with HCPCS modifier Q6 (services furnished by a locum tenens physician). Until further notice, the regular physician must keep on file a record of each service along with the substitute physician's UPIN.

If postoperative services are furnished by the substitute physician, the services cannot be submitted with HCPCS modifier Q6 since the regular physician is paid a global fee.

If services are provided by a substitute physician over a continuous period of longer than 60 days, the regular physician must submit the first 60 days with HCPCS modifier Q6. The substitute physician must submit for the remainder of the services in his/her own name. The regular physician may not submit and receive direct payment for services over the 60-day period. A new period of covered visits can begin after the regular physician has returned to work. For a medical group billing under the locum tenens arrangement, it is assumed that the locum tenens physician is paid by the regular physician. The term "regular physician" includes a physician who has left the group and for whom the group has hired the locum tenens physician as a replacement. A physician who has left a group, and for whom the group has engaged a locum tenens physician as a temporary replacement, may still be considered a member of the group until a permanent replacement is obtained.

General Guidelines for Modifier Use

A. Not all codes will require modifiers.

* Do not use a modifier if the narrative definition of a code indicates multiple occurrences.
EXAMPLES:
The code definition indicates two to four lesions. The code indicates multiple extremities.

* Do not use a modifier if the narrative definition of a code indicates that the procedure applies to different body parts.
EXAMPLES:
Code 11600 (Excision malignant lesion, trunks, arms, or legs; lesion diameter 0.5 cm. or less)
Code 11640 (Excision malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm. or less)

* Modifiers -GN, -GO, and -GP must be used to identify the therapist performing speech language therapy, occupational therapy, and physical therapy respectively.

B. Issues to Consider

The following are some general guidelines for using modifiers. They are in the form of questions to be considered. If the answer to any of the following questions is yes, then it is appropriate to use the applicable modifier.

1. Will the modifier add more information regarding the anatomic site of the procedure?
EXAMPLE:
Cataract surgery on the right or left eye.
2. Will the modifier help to eliminate the appearance of duplicate billing?
EXAMPLE:
Use modifier -77 to report the same procedure performed more than once on the same date of service but at different encounters.

3. Would a modifier help to eliminate the appearance of unbundling?
EXAMPLE:
Codes Q0081 (Infusion therapy, using other than chemotherapeutic drugs, per visit) and 36000 (Introduction of needle or intra catheter, vein): If procedure 36000 was performed for a reason other than as part of the IV infusion, modifier -59 would be appropriate.

Modifiers -LT and -RT

* Modifiers -LT or -RT apply to codes which identify procedures which can be performed on paired organs, e.g., ears, eyes, nostrils, kidneys, lungs, and ovaries.
* Modifiers -LT and -RT should be used whenever a procedure is performed on only one side. Hospitals use the appropriate -RT or -LT modifier to identify which of the paired organs was operated upon.
* These modifiers are required whenever they are appropriate.

Modifier	E	A	S	R	P/L	M	Description
21	X						Prolonged Evaluation and Management Services
22		X	X	X	X	X	Unusual Procedural Services
24	X						Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period
25	X						Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
26				X	X	X	Professional Component
32	X	X	X	X	X	X	Mandated Services
47			X				Anesthesia by Surgeon
50			X				Bilateral Procedure
51		X	X	X		X	Multiple Procedures
52	X		X	X	X	X	Reduced Services
53		X	X	X	X	X	Discontinued Procedure
54			X				Surgical Care Only
55			X			X	Postoperative Management Only
56			X			X	Preoperative Management Only
57	X		X				Decision for Surgery
58			X	X		X	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period
59		X	X	X	X	X	Distinct Procedural Service
62			X	X			Two Surgeons
63			X	X			Procedure Performed on Infants less than 4 kg:
66			X	X			Surgical Team
76			X	X		X	Repeat Procedure by Same Physician
77			X	X		X	Repeat Procedure by Another Physician
78			X	X		X	Return to the Operating Room for a Related Procedure During the Postoperative Period
79			X	X		X	Unrelated Procedure or Service by the Same Physician During the Postoperative Period
80			X	X			Assistant Surgeon
81			X				Minimum Assistant Surgeon
82			X				Assistant Surgeon (when qualified resident surgeon not available)
90			X	X	X	X	Reference (Outside) Laboratory
91			X	X	X	X	Repeat Clinical Diagnostic Laboratory Test
99			X	X		X	Multiple Modifiers
TC				X	X	X	Technical Component
GA*	X	X	X	X	X	X	Advance notice has been given to the beneficiary
GY*	X	X	X	X	X	X	Item or services statutorily excluded or does not meet the definition of any Medicare benefit
GZ*	X	X	X	X	X	X	The provider has reason to believe the claim may be denied and that the provider failed to obtain a signed ABN
Q5*	X	X	X	X	X	X	Services furnished by a substitute physician under a reciprocal billing arrangement
Q6*	X	X	X	X	X	X	Services furnished by a locum tenens physician

Note: * Indicates for use with Medicare or Railroad Medicare only						

ANESTHESIA MODIFIERS	
USE WITH CPT 00100 - 01999	
P1	**A normal healthy patient**
P2	**A patient with mild systemic disease**
P3	**A patient with severe systemic disease**
P4	**A 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**
AMBULATORY SURGERY CENTER AND HOSPITAL OUTPATIENT MODIFIERS	
25	**Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service**
27	**Multiple Outpatient Hospital E/M Encounters on the Same Date**
50	**Bilateral Procedure**
52	**Reduced Services**
58	**Staged or Related Procedure or Service by the Same Physician During the Postoperative Period**
59	**Distinct Procedural Service**
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:**
76	**Repeat Procedure by Same Physician**
77	**Repeat Procedure by Another Physician**
78	**Return to the Operating Room for a Related Procedure During the Postoperative Period**
79	**Unrelated Procedure or Service by the Same Physician During the Postoperative Period**
91	**Repeat Clinical Diagnostic Laboratory Test**
HCPCS MODIFIERS	
E-1	**Upper left, eyelid**
E-2	**Lower left, eyelid**
E-3	**Lower left, eyelid**
E-4	**Lower right, eyelid**
F-1	**Left hand, second digit**
F-2	**Left hand, third digit**
F-3	**Left hand, fourth digit**
F-4	**Left hand, fifth digit**
F-5	**Right hand, thumb**

F-6	**Right hand, second digit**
F-7	**Right hand, third digit**
F-8	**Right hand, fourth digit**
F-9	**Right hand, fifth digit**
FA	**Left hand, thumb**
GG	**Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day**
GH	**Diagnostic mammogram converted from screening mammogram on same day**
LC	**Left circumflex coronary artery (Hospitals use with codes 92980 92981 92982 - 92984, 92995, 92996)**
LD	**Left anterior descending coronary artery (Hospitals use with codes 92980 92981 92982 -92984, 92995, 92996)**
LT	**Left side (used to identify procedures performed on the left side of the body)**
QM	**Ambulance service provided under arrangement by a provider of services**
QN	**Ambulance service furnished directly by a provider of services**
RC	**Right coronary artery (Hospitals use with codes 92980 92981, 92982 -92984, 92995, 92996)**
RT	**Right side (used to identify procedures performed on the right side of the body)**
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**
TA	**Left foot, great toe**

REFERENCES:

All of the references listed below were obtained via public domain locations.
CMS NCCI Manual
CMS Medicare Reimbursement Manual
American Medical Association, CPT Manual
Blue Cross and Blue Shield Coding Policy Manuals
Noridian Medicare Coding Policy Manual
Palmetto GBA Coding Policy Manuals
Tricare Coding Policy Manuals