Modifiers:
It’s All in the Detail

Katherine Abel, CPC, CPC-I, CMRS
Director of Curriculum

AMA Disclaimer

Common procedural terminology (CPT®) codes, descriptions, and material only are Copyright 2009 American Medical Association (AMA). All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.
Objectives

• Learn how to keep from using the game of chance on modifiers.

• Explore the use of modifiers in detail.

• Review examples of appropriate and inappropriate uses for modifiers.

What is a Modifier?

A way for a provider to tell the insurance carrier the procedure billed has been altered in some way
Types of Modifiers

• HCPCS Level I - CPT® Modifiers

• HCPCS Level II Modifiers

Anesthesia Modifiers

• 23 – Unusual Anesthesia

• 47 – Anesthesia by Surgeon

• Physical Status Modifiers
Modifier 23
Unusual Anesthesia

- General anesthesia is used when procedure typically requires only local or regional anesthesia.

- Patient exhibits physical or medical compromising situations.

Example:
Six-year-old boy presents to the ER with a fish hook in his finger. Typically, the removal of fish hook would be performed under local anesthesia.

The boy is hysterical and the ED physician is unable to hold the boy’s hand still. General Anesthesia is required to remove the fish hook.
Modifier 47
Anesthesia by Surgeon

• Regional or general anesthesia provided by the surgeon

• Example:
  A orthopedic provider gives a patient a regional block before manipulating and repairing a compound fracture.

Anesthesia
Physical Status Modifiers

– 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
E/M Modifiers

• 25 – Significant, separately identifiable EM service by the same physician on the same day of the procedure or other service

• 57 – Decision for Surgery

• 24 – Unrelated EM service by the same physician during a postoperative period

Modifier 25
Separately Identifiable E/M

Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
Modifier 25
Separately Identifiable E/M

Questions to ask:
1. What was the patient scheduled for?
2. Was the procedure planned for that DOS?
3. Did the physician have to perform extra work for the additional procedure or service?
4. Did a new sign or symptom require evaluation before being treated?

Modifier 25 Logic Tree

Yes
- Does the documentation support the patient’s condition required a separate and significant E/M service, above and beyond the normal pre-operative and post-operative service for the procedure?
  - Yes
    - Does documentation in the medical record support the significant circumstance?
      - Yes
        - Does documentation define the medical necessity for the E/M service with the procedure?
          - Yes
            - Submit the E/M service with modifier 25
          - No
            - Is the E/M service provided when the initial decision to perform a surgery is made?
              - Yes
                - Report the E/M service with a modifier 57
              - No
                - Report only the procedure without the E/M service and modifier 25
      - No
        - Report only the procedure without the E/M service
  - No
    - Report only the procedure without the E/M service

No
- Do not bill the E/M service with the procedure
- Report only the procedure without the E/M service
Modifier 25
Separately Identifiable E/M

Example 1:
Patient is seen by his physician for hypertension and knee pain. The patient is evaluated for his hypertension and knee pain. The physician gives the patient a therapeutic injection in the knee (minor procedure).

Because the procedure was not planned prior to the examination, the E/M service is separately reportable with modifier 25.

Modifier 25
Separately Identifiable E/M

Example 2:
The patient is back at the physician's request for another injection two weeks after the first injection.

The physician performs a brief assessment of the knee pain and gives the patient an injection.

Modifier 25 is not appropriate in this case because the procedure was planned.
Modifier 57
Decision for Surgery

• Appended to the office visit resulting in the decision for surgery.

• Office visit should be the day before or the same day as the surgery.

• Major surgery (depending on payer guidelines).

Example:

CC: Follow up tibial osteomyelitis
P.I.: The patient is a 67-year-old male. He has had the tibial osteomyelitis treated with sterile debridement and irrigation. He has a vac. He has been on IV Vancomycin and p.o. Levaquin.

P.E.: The vac is removed. He has gross purulence in the tibia calcaneal and in the wound. There is draining puss.

IMP.: Left tibial osteomyelitis.

PLAN: He is admitted to the hospital today. We essentially failed limb salvage with this patient. He has had five or six debridements. He looked great at the time of discharge last week. Apparently his wound looked good on Saturday and it has worsened just over the last several days. We are going to recommend an amputation at this point. Please see H&P notes for further details. We will proceed with the amputation tomorrow.
Modifier 24

Unrelated Evaluation and Management Service by the Same Physician During Postoperative Period

Example:

January 22 - CC: Injury to the right hand

HPI: The patient was using a drill press and caught his hand injuring his ring finger and his index finger. He is right hand dominant. This occurred at his home. He had no other injury.

Description of Procedure: The patient was given a digital block with Lidocaine. He was then prepped and draped in the sterile fashion. His index finger laceration was repaired with 4-0 nylon suture. The ring finger was amputated at the DIP joint with residual bone being removed; the neurovascular bundles were cut proximal to the tip. Skin flaps were fashioned and closed with multiple 4-0 nylon sutures. The longitudinal laceration of the volar aspect of his finger was also repaired loosely with 4-0 nylon suture. A bulky dressing was applied. The patient had been given Ancef and tetanus was updated. I sent him home on Keflex and Lortab. He will follow up with me in 48 hours for wound check. Remain off work.

March 15 - CC: Right Shoulder Pain

PI: 47 year-old, otherwise healthy, right hand dominate male tool maker at Saturn with a 6-8 week history of gradual insidious onset of right shoulder pain. The pain began prior to the amputation of his right ring finger. The pain seems to be localized more laterally.

PE: Exam, right shoulder is non-swollen. No deformity. No muscular atrophy. He does have crepitus that localizes to his scapulothoracic articulation medially and posteriorly, but there is no tenderness or apparent pain. He has full active range of motion. Negative drop test. No instability. Negative impingement. He does have some pain primarily with resisted supraspinatus function, but no distinct weakness.

PLAN: Findings consistent with above diagnosis. After discussion of treatment options, he wished to proceed with injection which was done with 2 cc of steroid and 8cc of Xylocaine under a sterile technique from a posterior approach.
Modifier 24
Unrelated E/M During Postoperative Period

Example:
January 22 – Patient is seen for an injury to right index finger. The patient’s finger is amputated at the DIP joint.

March 15 – Patient is seen by the same physician for pain in the same finger. The physician determined it was part of the normal recovery process from the amputation.

Modifier 24 would not be appropriate since it is related to the surgery.

CMS 104c12 30.6.3 – Payment for Immunosuppressive Therapy Management

• Office or Subsequent Hospital Visit Codes
• Same physician who performed transplant
• Bill with Modifier 24
• Submit documentation
Global Package Modifiers

- 54 – Surgical Care Only (services necessary as part of the procedure)
- 55 – Postoperative Management Only (follow up visits related to recovery from surgery)
- 56 – Preoperative Management Only (day before and day of surgery)

Common uses:
- Rural Areas
- Specialty Surgeries

Check with your payers:
- Physicians are in same group
- Payment is made to the group
- May bill global under physician who actually performed the surgery.
Global Package Modifiers

• 78 – Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period

• 79 – Unrelated Procedure or Service by the Same Physician During the Postoperative Period

Modifier 78
Unplanned Return to Operating Room – Related Procedure

• Return to operating room:
  – During the postoperative period
  – One or more additional procedures
  – Result of complication of the original surgery (not defined by CPT® definition...check with payer)

• Does not apply when repeated during the same operative session

• Payment made for intraoperative service only (no pre-op or post-op)
Modifier 78
Unplanned Return to Operating Room – Related Procedure

Example 1:
Patient is seen in March for a cataract surgery. In June, the patient returns to the operating room for a posterior capsulotomy.

Example 2:
Patient has a gastric bypass surgery in January. In March, the patient is diagnosed with an incisional hernia. The patient is taken back to the operating room in March for incisional hernia repair with abdominoplasty.

Modifier 79
Unplanned Return to Operating Room – Unrelated Procedure

Example:
January 22 – Patient is seen for an injury to right index finger. The patient’s finger is amputated at the DIP joint.

March 15 – Patient has an amputation of the right leg.
Surgical Modifiers

• 22 – Increased Procedural Service
• 50 – Bilateral Procedure
• 51 – Multiple Procedures
• 52 – Reduced Services
• 53 – Discontinued Procedure

Modifier 22
Increased Procedural Service

• Services required to perform the procedure are significantly greater than usually reported with the procedure.

• WPS Medicare: intended for anatomical variants.

• Bill with:
  – Operative report
  – Letter indicating precise reason services were above usual
Documentation in the medical record supports the unusual service(s)

Physician prepares a written report and separate cover letter detailing the “unusual” circumstances

Append the procedure code with modifier 22 and submit with documentation

Documentation in the medical record does not support unusual services

Do not submit the claim with modifier 22

Modifier 22
Increased Procedural Service

Example:

During a colonoscopy, the patient has a 1 cm polyp removed. The removal of the polyp causes excessive bleeding. An extra 30 minutes were spent controlling the bleeding.
Modifier 50
Bilateral Procedure

• Check with payers on how to bill.

• Regence BCBS – one line item, modifier 50, 1 unit

• CMS
  – One line item with modifier 50
  – Two line items with LT & RT

• Do not use on procedures specified as bilateral procedures.

Example 1:
The patient presents for a bilateral orchiectomy. The penis and scrotum were prepped and draped in the usual fashion. The testes were removed. Drains were placed adjacent to the spermatic cord stumps and brought out through the inferior portion of the scrotum. The patient tolerated the procedure well and was returned to the recovery unit.
Modifier 50
Bilateral Procedure

Example 2:
PREOPERATIVE & POSTOPERATIVE DIAGNOSIS: Ptosis, o.u.
OPERATION PERFORMED: Upper lid blepharoplasty, o.u.
OPERATIVE PROCEDURE:
The patient was brought to the operative suite and laid supine upon the operative table. After the appropriate anesthetic lines were placed, before any anesthetic was given, the patient was marked using a skin marking pen as follows: Both eyes were done in the same fashion. A mark was made 10 mm above the lash line central lid 6 mm above the lateral canthus and 4 mm above the medial canthus. This was joined in a curvilinear fashion to correspond to the lid crease. The upper border of the incision line was determined by taking a large curved forceps and grasping the skin to not cause eversion of the lid but to pull it tight and then the uppermost extension was marked. The points were joined together in elliptical fashion with a lazy “S” shape going out over the lateral canthal area. 2% Lidocaine with epinephrine was injected using a 30-gauge needle along the incision lines and into the fat pockets on both sides. During this step, the patient was given some sedative. The patient was then prepped and draped in usual sterile fashion. Then a drop of anesthetic was placed in the eye and a protective contact lens was placed over the cornea to provide substantial corneal and scleral protection. A #15 Bard-Parker blade was used to make a skin incision along the predetermined marked line and then a skin muscle flap was raised by grasping the lateral corner and using blunt Westcott scissors dissecting the skin muscle flap from the underlying layers. Care was taken not to disrupt the levator aponeurosis or the septum. The bleeds were isolated and stopped with cautery. The medial fat pockets were very prominent, so they were gently incised and some pressure placed around them to prolapse the fat. It was clamped, cut and cauterized and allowed to retract back after it was ensured there was no bleeding. The exact same procedure was done on both sides and then a running #6-0 nylon suture was used to close the wound. The corneal shields were removed. Antibiotic ointment was placed along the incision lines and a gel pack cool pack was placed over the wound and on top of that a cloth and then followed by an ice pack. The patient’s head of the bed was elevated and she was sent to the recovery area in good condition.

Modifier 50
Bilateral Procedure

Caution:
27215 – 27218 Treatment of Pelvic Fractures
27215 Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral, for pelvic bone fracture patterns that do not disrupt the pelvic ring, includes internal fixation, when performed.
(To report bilateral procedure, report 27215 with modifier 50)

G0412 – G0415 Treatment of Pelvic Fractures (For Medicare Patients)
G0412 - Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral or bilateral, for pelvic bone fracture patterns which do not disrupt the pelvic ring, includes internal fixation, when performed.
Modifier 52
Reduced Services

- Service is not completed in its entirety
- Physician’s discretion

Example:
Prescription and fitting of contact lens, both eyes, performed on one eye.

CPT® parenthetical instruction:
(For prescription and fitting of one eye, add modifier 52)

Modifier 52
Reduced Services

CPT® Professional:

“For an incomplete colonoscopy, with full preparation for a colonoscopy, use a colonoscopy code with the modifier 52 and provide documentation.”
Modifier 53
Discontinued Procedure

• Terminated due to:
  – Extenuating circumstances
  – Circumstances threatening the well-being of the patient

• Do not use to report the elective cancellation of a procedure prior to anesthesia induction and/or surgical prep in the surgical suite.

Surgical Modifiers (continued)

• 58 – Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

• 59 – Distinct Procedural Service
Modifier 58
Staged or Related Procedure

- Planned prospectively at the time of the original procedure
- More extensive than the original procedure
- Therapy following a surgical procedure

Modifier 58 Logic Tree

Yes
Did the same physician perform a procedure or service during the postoperative period that was:
(a) planned or anticipated (staged),
(b) more extensive than the original procedure, or
(c) for therapy following a surgical procedure?

No
Refer to modifier 78 or 79 if the patient is returned to the operating room for a related or unrelated procedure that does not meet the criteria of modifier 58

- Does the diagnosis code support the service billed?
- Does the documentation clearly support the definition of modifier 58?
- Append modifier 58 to the "staged" procedure
- Submit claim with modifier 58 appended to the procedure or service

Deborah J. Grider; Coding with Modifiers
Modifier 58
Staged or Related Procedure

Example 1:
December 18 – patient undergoes debridement and irrigation of bone of left tibia. The operative note states, “we need daily debridements at this point.”

December 19 – patient returns for another debridement.

Same CPT® code billed

Example 2:
December 13 – Patient has debridement and irrigation to bone of left tibia. End of note states “patient does understand he is at high risk for amputation with this problem.”

January 1 – Patient has an above the knee amputation.

Modifier 58 would be used on AK amputation
Modifier 59
Distinct Procedural Service

- Procedures not normally reported together
- Different Session or Patient Encounter
- Different Procedure or Surgery
- Different Site or Organ System
- Separate Incision/Excision
- Separate Lesion
- Separate Injury

Modifier 59 Logic Tree

Yes
Was the service distinct and separate from other services performed on the same day?
- Was the procedure performed on, for example, a different organ, different site, different lesion?
- Was the procedure performed by the same physician on the same day?
- Is there another modifier that further explains the circumstance in lieu of modifier 59?

No
Review other modifiers before submitting the claim

Consider using another Modifier (51, 76, RT, LT)

Append modifier 59 to the procedure or service that is distinct and separate

© 2007 American Medical Association. All rights reserved.
Modifier 59
Distinct Procedural Service

Example 1:
During a colonoscopy, proximal to the splenic flexure, a lesion is removed by snare technique.

During the same colonoscopy, a biopsy is taken of a different lesion.

Both codes are reportable.

Modifier 59
Distinct Procedural Service

Example 2:
DESCRIPTION OF PROCEDURE:
Description of the colonoscopy: Risks and benefits were explained to the patient before the EGD, and informed consent was obtained. The patient's stretcher was rotated in the room. He was in the left lateral decubitus position, and a digital rectal examination was performed. Then, under direct visualization a video colonoscope was passed into the rectum. The scope was retroflexed with examination of the anorectal junction, which revealed hemorrhoids. The scope was deflected, passed through the entire colon to the level of the cecum. There was a large 4 cm polyp at the cecum, which was grabbed with snare wire, removed with electrocautery, and suctioned to a trap. There were three 5 mm polyps at the ascending colon that were grabbed with snare wire, removed with electrocautery, and suctioned to a trap. There was a 1 cm broad flat carpeting polyp that was removed with snare polypectomy technique multiple times and India ink tattooed for demarcation and suctioned to a trap. The scope was brought to the level of the hepatic flexure where a 5 mm polyp was grabbed with a snare wire, removed with electrocautery, and suctioned to a trap. There was a large pedunculated polyp measuring about 1 cm at the descending colon that was grabbed with a snare wire, removed with electrocautery, and suctioned to a trap. Diverticulosis was noted throughout the colon predominantly in the sigmoid colon.

At the sigmoid colon, two 1-mm sessile polyps were grabbed with a snare wire, removed with electrocautery, and suctioned to a trap. Prep was suboptimal with some semisolid stool predominantly in the rectosigmoid. No other polypoid lesions or masses were seen. Air was suctioned, and the scope was removed. The patient tolerated the procedure well.
Surgical Modifiers (continued)

- 63 – Procedures performed on infants less than 4 kg
- 76 – Repeat procedure or service by same physician
- 77 – Repeat procedure by another physician

Modifier 63
Procedures Performed on Infants Less than 4 Kg

- Increased work intensity:
  - Temperature control
  - Obtaining IV access
  - Maintenance of homeostasis

- Not used when procedures specifies the present weight of less than 4 kg
Modifier 76
Repeat Procedure or Service by the Same Physician

Example:
Patient presents to the ED with trauma to the chest. A chest X-ray reveals pneumothorax. A chest tube is placed and a repeat chest X-ray is performed to verify the placement of the chest tube.

Modifier 77
Repeat Procedure by Another Physician

Example:
Patient visits his family practitioner with chest pain. The physician performs an EKG and refers the patient to a cardiologist. The patient is able to see the cardiologist the same day. The cardiologist performs a repeat EKG.
Multiple Surgeon Modifiers

• 62 – Two Surgeons
  – Two surgeons of different specialties performing one procedure
  – Two surgeons of same specialties performing different parts of the procedure

• 66 – Surgical Team
  – More than two surgeons

Assistant Surgeon Modifiers

• 80 – Assistant Surgeon

• 81 – Minimum Assistant Surgeon

• 82 – Assistant Surgeon (when qualified resident surgeon not available)

• AS – Non-MD Surgical Assistant
Ancillary Modifiers

- Global – a procedure containing both a technical and a professional component
- Modifier 26 – Professional component
- Modifier TC – Technical component

Example:
The patient presents to your office with chest pain. Your office takes the X-ray, but sends it out to be read by a radiologist.

Office bills modifier TC
Radiologist bills modifier 26
Laboratory Modifiers

• 90 – Reference (Outside) Laboratory
  – Medicare: Only claims submitted by independent laboratories
  – Other insurers: Used to bill for lab services purchased from an outside lab

• 91 – Repeat Clinical Diagnostic Laboratory Test
  – Should not be used to confirm results
  – Should not be used to repeat a test due to equipment malfunction

• 92 – Alternative Laboratory Platform Testing
  – HIV testing 86701 - 86703

Miscellaneous Modifiers

Modifier 32 – Mandated Service

– Most common use: Workers’ Compensation

– Not recognized by Medicare

– Not to be used when the patient and/or family requests a second opinion
Questions?

Thank you!