Understanding Modifiers

Comprehensive instruction to effective modifier application
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determinations (LCDs), and national coverage determinations (NCDs) for regional determinations.

OUTPATIENT MODIFIER GUIDELINES/USAGE
CMS, through hospital Transmittal 726, dated January 1998, initially identified CPT and HCPCS Level II modifiers for hospital use when billing outpatient services (effective date July 1, 1998). Modifiers are required to ensure payment accuracy, coding consistency, and accurate editing under the outpatient prospective payment system (OPPS). The modifiers are reported as an attachment to the HCPCS code as reported in the UB-04 form locator (FL) 44 or for electronic submission field Loop 2400, SV202-3 of the 837i format. For example, a bilateral nasal sinus endoscopy with total ethmoidectomy would be reported as 31255-50.

CONTENTS
Organization
Optum360 Learning: Understanding Modifiers is a reference for physicians and their staff as well as for billers and coders of hospital outpatient services and ASC services. It includes sections that will help physicians or facility coders validate medical record documentation to support the appropriate use of the assigned modifiers. The book also includes a chapter detailing compliance issues as they relate to modifier reporting.

Each section lists specific groupings or types of modifiers, including the complete official AMA definitions. For each grouping of similar modifiers, guidelines are provided in the following format:

• Appropriate and correct use
• Incorrect use
• Coding tips and guidance as well as local coverage determinations, as applicable
• Clinical examples (when appropriate)

The clinical examples provided illustrate correct modifier usage. For additional guidance, logic trees have been developed to help determine which modifier should be applied in various situations (see chapter 13).

Chapter 11 contains a list of all HCPCS Level II modifiers. Specific instructions for appropriate use are provided where information is available.

MULTIPLE MODIFIERS
Sometimes, more than one modifier must be reported for a submitted CPT or HCPCS code. In such a case, the modifier that may affect payment is listed first, followed by additional appropriate modifiers. It may be necessary, for example, to report that the nerve repair of a finger was performed on multiple digits. Modifier 51 would be listed, followed by the HCPCS modifier identifying the specific finger involved.

The Office of Inspector General work plan typically includes modifier usage. To view the most recent OIG work plan, visit http://oig.hhs.gov/reports-and-publications/workplan/index.asp.

CMS online manuals, Pub 100-04, Claims Processing Manual, chapter 12, section 40.9, contains a listing of all procedures billed with two or more surgery modifiers.
making is of low complexity. Finally, a tetanus toxoid inoculation is administered. The signs for intracranial pressure changes are reviewed with the patient and he is given follow-up instructions.

Report CPT code 99203-25 for the history, physical, and medical decision making portions of the E/M visit, and report code 12032 for the layered closure of the open scalp wound. Report code 90703 for the tetanus inoculation. All services should be linked to the same ICD-10-CM code for open wound of the scalp (S01.01XA).

**Example #3:**
An established patient presents with uterine bleeding requiring a hysteroscopy with endometrial biopsy; the patient is also evaluated for a breast cyst. The breast evaluation consists of an expanded problem-focused history and physical exam and medical decision making of low complexity.

In this case, only the E/M elements of the visit related to the breast cyst would be used to justify the correct level of service for the office visit.

Submit CPT codes 99213-25 and 58558. The diagnosis for the breast cyst would be linked to the E/M service code (99213-25), and the diagnosis for the uterine bleeding would be linked to the hysteroscopy procedure (58558).

**Modifier 57**
- The CPT book defines modifier 57 as representing an E/M service that resulted in the original decision to perform surgery; Medicare guidelines indicate that this modifier should be used when the E/M service performed the day before or the day of surgery resulted in the decision for major surgery (i.e., those with a 90-day follow-up period). Medicare guidelines further instruct coders to use modifier 25 if the decision for surgery is made on the same day as a minor surgery (i.e., in those with a zero- to 10-day follow-up period) or diagnostic procedure.
- Use of modifier 57 on a minor procedure may be appropriate with some third-party payers; consult with the specific payer to clarify its definition of a “minor” procedure and whether modifier 57 can be used on such codes.
- Modifier 57 can be appended only to an E/M code (99201–99499) and ophthalmological codes 92002, 92004, 92012, and 92014, unless limited by the payer.
- This modifier is one of a group of CPT modifiers (24, 25, 57, 58, 78, and 79) that identify an E/M or certain ophthalmological service furnished during a global surgery period that is not normally a part of the global surgery package.

**Modifier 57: Clinical Examples of Appropriate Use**

**Example #1:**
This 75-year-old white male, well-known to the hospital GI clinic, collapsed in the waiting room. He was brought into an exam room, with hematemesis. An electrocardiogram was performed and interpreted as negative for acute changes, but a Q wave was noted, indicative of a previous myocardial infarction (MI). He awakened after several minutes. The patient states he has noted bloody stools for two days but today
modifier 50, or a two-line item with modifier 50 placed on the second (bilateral) procedure code.

**Modifier 51**

- When multiple procedures, other than E/M services, are performed on the same day or at the same session by the same provider, report the primary procedure or service and append modifier 51 to the appropriate CPT codes for the additional services or procedures.
- Do not use modifier 51 with add-on codes. Add-on codes are procedures performed in addition to the main procedure and by CPT definition should be reported without modifier 51.
  - Add-on codes represent procedures that cannot be performed alone. Examples of words to look for as clues to add-on procedures are each additional, list in addition to, and second lesion.
- Medicare recognizes that multiple modifiers are often reported with surgical procedures. Other modifiers that may be reported with modifier 51 include 50, 54, 55, 62, 66, and 80. CMS also recognizes modifiers 50, 62, and 54 when reported together as well as 50, 66, and 54.
- Check the MPFSDB for an indicator that will show whether modifier 51 can be appended to the procedure code for Medicare claims.
- CPT codes for use with modifier 51 unless limited by the payer are 10021–69990, 70010–79999, 90281–99199, and 99500–99607, when appropriate.

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**Modifier 51: Clinical Examples of Appropriate Use**

**Example #1:**
A 20-year-old male is transported to the ED via ambulance for multiple lacerations after walking into a glass door. After the initial examination, the ED physician performs debridement and repair of the following lacerations:
- 2.6 cm scalp laceration, simple 12002
- 2.4 cm neck laceration, simple 12001
- 2.3 cm facial laceration, simple 12011
- 2.4 cm eyelid laceration, intermediate 12051
- 2.5 cm forearm laceration, complex 13120

The following CPT codes are submitted, following the CPT code book guidelines for repair (closure) of wounds. Note that the lengths of two of the wounds are within the same classification and level, so their lengths should be added together.

When reporting wounds within the same classification and level, the lengths of each of the wounds repaired should be added together and reported under the same CPT code designating the sum of those particular wound repair lengths. Classification is the grouping of like tissue types such as scalp, neck, external genitalia, trunk, and extremities. Another such classification involves the face, ears, eyelids, nose, lips, and mucous membranes. The level of repair is classified as simple, intermediate, or complex. In clinical example 1, note that the CPT code 12001 for the 2.4 cm laceration is not reported separately; it is combined with the length of the similarly classified wound described by CPT code 12002. Therefore, these repairs are reported only by the single CPT code 12002, which represents a total wound repair length of 5.0 cm. This CPT code describes a wound length of 2.6 cm to 7.5 cm.
• Using modifiers 26 and TC (except for purchased diagnostic tests) when a diagnostic test or radiology service is performed globally (both components are performed by the same provider). When a global service is performed, the code representing the complete service should be reported without modifiers. The payment for the global service reflects the allowances for both components.

• Do not append these modifiers to:
  – professional component-only procedure codes, identified in the MPFSDB by an indicator “2” in the PC/TC column
  – global-only procedures, identified in the MPFSDB with an indicator “4” in the PC/TC column
  – technical component only procedure codes, assigned an indicator “3” in the MPFSDB PC/TC column

Regulatory and Coding Guidance for Professional and Technical Component Modifiers

**Modifier 26**

• Some procedure/service codes represent a blend of both the provider and facility components. To report only the provider portion of the global service, append modifier 26 to the procedure/service code.

• To use the professional component modifier 26, the provider must prepare a written report that includes findings, relevant clinical issues and, if appropriate, comparative data. This report must be available if requested by the payer. A review of the diagnostic procedure findings, without a written report similar what would be prepared by a specialist in the field, does not meet the conditions for modifier use. The review of the findings, usually documented in the medical record or on a machine-generated report as “fx-tibia” or “EKG-WNL with inverted Q-waves on lead II” does not suffice as a separately identifiable report and is not eligible for payment. These types of procedural review notes should be bundled into any E/M code billed for that date. If a post-payment review of the medical record reveals that no separate, written interpretive report exists, overpayment recoveries may be sought.

• CPT® codes for use with modifier 26 are 10021–69990, 70010–79999, 90281–99199, and 99500–99607 unless limited by the payer. Payer policies regarding the use of modifier 26 with laboratory services vary.

**Modifier 26: Clinical Examples of Appropriate Use**

**Example #1:**
A complex cystometrogram is performed by a urologist and a certified technician in a hospital outpatient setting.
Submit code 51726-26. When the physician only interprets the results (or only operates the equipment), a professional component modifier 26 should be used to identify the physician’s services.

**Example #2:**
The patient presents to the hospital urology outpatient clinic for a penile plethysmography due to priapism. The physician is present during the procedure and interprets the results.
Submit CPT code 54240-26.

CODING AXIOM

Appropriate use of modifier 26 requires the provider to prepare a written report that includes findings, relevant clinical issues, and if applicable, comparative data.
Modifier 47

Did the physician performing the procedure also administer anesthesia?

Yes

Is this a Medicare patient?

No

If anesthesia was administered by an anesthetist and not the performing physician...

Yes

Append modifier 47 to the service code.

No

Submit claim and monitor reimbursement. May require documentation by payer.

Medicare does not recognize this modifier. Anesthesia administration by the performing physician is considered included in the payment for the procedure.

Submit the CPT code for the procedure only. If modifier 47 is used it is informational only.