A REVIEW OF COMMON MODIFIERS
*IN PHYSICIAN BILLING

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INSTRUCTOR

- Podcast Creator: For the Love of Revenue Cycle
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Modifiers indicate that a service or procedure performed has been altered by some specific circumstance, but not changed in its definition or code. AMA®

- Chosen based on medical documentation
- Improve accuracy or specificity
- Two digit alphabetic, numeric or alphanumeric
**Same physician**
- Physicians in the same group practice who are of the same specialty

**Qualified Healthcare Professional (QHP)**
- Individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.
CMS Global Surgical Package
• all the necessary services normally furnished by a surgeon before, during, and after a procedure

CPT® Surgical Package Definition
• E/M services
• Anesthesia
• Immediate post-op care
• Writing orders
• Recovery area
• Typical post-op care
Minor surgery
• 0-day global period
• 10-day global period

Major surgery
• 90-day global period

Billing Guidance

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Evaluation and Management (E/M; E&M)

- Office visit
- Hospital visit
- Consultation
- ER visit
- SNF visit
- Home visit

Procedure
- CPT® Surgery section
GLOSSARY

National Correct Coding Initiative (NCCI)
• Procedure-to-Procedure (PTP)
• Medically Unlikely Edits (MUE)
• Add-On Code (AOC)

NCCI Modifiers
• Used to bypass PTP edits
Payment
• Affect reimbursement
• Must be listed first

Informational/statistical
• Doesn’t affect reimbursement
• May be listed in any order

Billing note: If appending more than one modifier, list pricing modifier first and then informational modifier (i.e. 59, RT)
CATEGORIES

- Global Surgery
- Surgical
- Therapy
- Telehealth
- Hospice
- Assistance to Surgery
- ABN

- HCPCS Level II
- Category II
- Anesthesia
- Anatomical
- Laboratory
- Podiatry
- Quality Reporting Incentive Program
PAYER VS. CODING GUIDELINES

There are times when coding and modifier information issued by payers differs from the American Medical Association’s coding guidelines regarding the use of modifiers.

A clear understanding of payer’s rules and regulations AND coding guidelines is necessary to assign the appropriate modifier.
MODIFIER USAGE EXAMPLES

• Billing for components of a global surgical package

• Identification of a specific body area

• To designate a bilateral procedure

• Identification of professional or technical only components

• Repeat services by the same or different provider

• An increased, reduced, or unusual service
GLOBAL SURGERY (E/M)
MODIFIER 24

Unrelated E/M by the same physician or other QHP during a postoperative period

- The E/M service occurs during the postoperative period of another procedure.
- The E/M service is unrelated to the previous procedure.
- The same physician (or tax ID or same group and specialty) who performed the previous procedure provides the E/M.
- Documentation needs to clearly indicate that the condition is not related to the post-operative care.
- The same diagnosis as the original procedure could be used for the new E/M if the problem occurs at a different anatomical site (laterality)
An established patient visits the same physician for heartburn during a post-op period for appendectomy.

Bill: 99213-24
A **significant, separately identifiable** E/M service by the **same physician or other QHP** on the **same day of a procedure or other service**.

- All procedures include some service related to patient evaluation and management; a separate E/M should include its own history, exam and medical decision-making (HEM)
- Documentation must support that the problem is significant enough to require additional work to perform the key components of the problem-oriented E/M service
MODIFIER 25
USAGE

- CMS (and most commercial payers): Only use when the procedure occurred on the same day as a procedure with global days.
- Some payers do require even if the procedure has no global days.
- Provider may also render two E/M services to the same patient on the same day; append modifier to 2nd E/M.
- Use in the rare circumstance of an E/M service the day before a major surgery that is not the decision for surgery and represents a significant, separately identifiable service.
MODIFIER 25
EXAMPLE

An established patient is treated by the physician for hypertension and then asks the physician to biopsy a soft tissue lump located on his back (10-day global period)

Bill: 99215-25, 21920

An established patient presents to have a skin tag removed; no separate HEM is performed

Bill: 11200
MULTIPLE E/M MODIFIERS

In some situations, it may be appropriate to bill more than one E/M modifier (i.e., 24, 25, 57, etc.) on the same E/M service.

Example: Physician provides an E/M and procedure not related to the previous procedure during the global period.

DOS 11/3/22
11200 (removal of skin tags – 10-day global)

DOS 11/6/22
99212-24, 25
11750-79 (excision of ingrown toenail)
Decision for Surgery: When an E/M service provided the day before or the day of a surgery results in the decision to perform major surgery.
Modifier 57 tells the payer that they must process the claim for the E/M service instead of including it in preoperative services in the surgical package payment for a major surgery.

To append modifier 57 properly, you must remember these points:

• The E/M service occurs the day of or the day before a major surgical procedure, a procedure with a 90-day global period.

• The E/M service must prompt the surgical procedure that follows.

• The E/M service must be related to the procedure that follows.

• The same provider or tax ID provides the E/M service and the surgical procedure.
A physician exams a patient in the ER and makes the decision to admit the patient and perform an appendectomy the same day.

**Bill:** 99283-57, 44950
GLOBAL SURGERY (PROCEDURES)
MODIFIER 58

Staged or related procedure performed during the postoperative period of the first procedure by the same physician.

• **Staged procedure**: Any operation undertaken in two or more separate parts, with a lull between the two stages to facilitate tissue healing or clearance of infection.

• A new postoperative period begins when the staged procedure is billed
**Appropriate usage**

Report when a procedure or service during the postoperative period was:

- Planned prospectively or at the time of the original procedure.
- More extensive than original procedure.
- For therapy following a diagnostic surgical procedure.

When performing a second or related procedure during the postoperative period


**Inappropriate usage**

- Staged procedures do not apply to claims for assistant at surgery.
- Appending the modifier to ambulatory surgical center (ASC) facility fee claims.
- Doesn’t apply to procedures with XXX global period.
- Unrelated procedures during the postoperative period.
- Reporting the treatment of a complication from original surgery that requires a return to operating room or service not separately payable that does not require a return to the operating room.
A 29-year-old patient who received a full-thickness burn of her left arm during a fire at her campsite several weeks back and had undergone primary reconstruction/debridement with a split-thickness graft. Two weeks after her initial treatment, she was advised there would be a return to the OR for the formation of direct pedicle with transfer but would need a little more healing first.

**Bill:** 15572-58
MODIFIER 78

**Unplanned** return to the operating or procedure room, by the same physician, **following an initial procedure** for a related procedure during the **post-operative period**.

- A new post-op period does not begin
- Allows for intraoperative percentage only
- An ‘operating room’ is a POS specifically equipped for procedures
MODIFIER 78
USAGE

Appropriate usage

• To identify a related procedure (that has 10 or 90 global surgery period) requiring a return trip to the operating room within the postoperative period of a major or minor surgery.
• To treat the patient for complications resulting from the original surgery.
• When the procedure code used to describe a service for a treatment of complications is the same as the procedure code used in the original procedure.
Inappropriate usage

• On any procedure code that does not have global period of 10 or 90
• When surgery is unrelated to the original procedure.
• On procedures performed in any place other than the operating room.
• On ambulatory surgical center (ASC) facility services.
Dr. Fudge performed a partial colectomy with skin level cecostomy on the patient on September 23rd, which had a 90-day global period. Due to a complication, the patient has returned to the OR on October 6th for a secondary suturing of the abdominal wall, which was related to the original surgery.

**Bill:**  
9/23  44141  
10/06  49900-78
MODIFIER 58 OR 78?

Similarities
• Only during the post-op or global period
• Affect the global period
• Directly affect reimbursement

Differences
• Modifier 58:
  • Expected return for staged procedure
  • More extensive than original procedure
    • Still treating the condition
  • For therapy following procedure
• Modifier 78:
  • Unplanned return
  • Complication of previously-performed procedure
MODIFIER 79

**Unrelated procedure or service by the same physician or other QHP during the post-op period**

- A new post-operative period begins when the unrelated procedure is billed.
MODIFIER 79

USAGE

• Use if the second surgery takes place on a different body part or different side of the body
• Use if the provider links a second procedure to a totally different diagnosis and does not mention a complication
• Do not use for repeat procedures
• Only use on procedures with global days
• Do not report on ASC services
Fred underwent cataract surgery on December 9\textsuperscript{th} on his right eye at the surgery center, which was deemed a success. He started having eye pains 3 weeks later in the left eye and it was determined he had a retinal detachment, so he was scheduled for this Thursday, January 4\textsuperscript{th} to have this corrected.

\textbf{Bill}: 12/9 66984- RT  
01/04 67107- LT-79
OTHER SURGICAL MODIFIERS
MODIFIER 50

**Bilateral procedures** performed during the same session (diagnostic, radiological, or surgical)

- Do not append to midline organs such as bladder, uterus, etc.
- Do not append if the ICD-10 or CPT code indicates laterality
- Remember that multiple procedure payment reduction applies
MODIFIER 50
USAGE

**Appropriate Use**: a patient undergoes surgery for a bilateral laparoscopic inguinal hernia repair (49650-50).

**Inappropriate Use**: trigger point injections for muscles on the right and left side of the body; code 20553 represents trigger point injections for 3 or more muscles, and laterality does not come into play.
MODIFIER 50
BILATERAL PROCEDURE BILLING

• **CPT:** Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code.

• **CMS:** Refer to MPFS “BILT SURG” indicators: 0, 1, 2, 3, 9

• Bilateral surgical procedure billing scenarios:
  • Two line items, each with 1 unit of service using modifiers LT and RT on different claim lines
  • Single line item, modifier 50 and 1 unit of service with double charge amount
  • Single line item, modifier 50, 2 units of service
MODIFIER 51

When multiple procedures are performed at the same session by the same provider.

Do not report modifier 51 with modifier 50, with add–on codes, with codes that are modifier 51 exempt, (see Appendix E of the CPT® manual), or with bilateral procedures.

Do not use modifier 51 with E/M services, physical medicine and rehabilitation services, or with supplies.
Excision of benign lesion of the arm, and excision of a benign lesion of the face during the same session

Bill: 11442, 11402-51
MODIFIER 59

**Distinct Procedural Service:** indicates a procedure or service was distinct or independent from other non-E/M services performed on the **same day** by the **same provider**.

- Identifies services that are not normally reported together but are appropriate under the circumstances
  - Different anatomic site/organ system
  - Different encounters on the same day
  - Separate incision/excision
  - Separate lesion/injury
MODIFIER 51 VS. 59

• Should not expect modifier 51 to affect whether or not the payer reimburses.

• Modifier 51 is an informational modifier for use on the second, third, etc., surgical procedure performed on the same day.

• Modifier 59 can actually affect whether a payer reimburses a claim.

• Modifier 59 tips off the payer that certain performed services are not normally done together, but an exception is appropriate in a particular case.
MODIFIER 59
CODE DESCRIPTORS

• Watch out for code descriptors: Some code descriptors include the words "separate procedure," which tells you that the procedure is separate from other procedures performed on the same patient, and that it is appropriate to append modifier 59.

• Other code descriptors include multiple procedures, a primary procedure with additional procedures, bundled under one code. Do not append modifier 59 to these codes.
MODIFIER 59
NCCI EDITS

Utilize NCCI modifier indicator in the CMS physician fee schedule

• CCMI (correct coding modifier indicator) of “0”
  • Column one code is eligible for payment
  • Column two code is denied

• CCMI of “1”
  • May be reported if documentation supports

• CCMI of "9"
  • NCCI editing does not apply.
• Evaluate other modifiers to determine whether modifier 59 is the most appropriate.

• It is very important that medical records include documentation to support the use of modifier 59 (or any other modifier).
  • Claims reporting modifier 59 on multiple lines for the same procedure code without a narrative or documentation to support the additional lines will be denied
  • Documentation provides a clinical picture of what was done and why a modifier was appropriate.
  • Often, the documentation received lacks evidence/clinical circumstance to substantiate its use, resulting in a denial.
• Different...
  • Session
  • Procedure
  • Site or organ system

• Second initial injection procedure
  • Two separate sites or when the
  • Patient has to come back for a separately identifiable service

• Evaluate other anatomical modifiers, i.e.:
  • RT/LT identifying right and left
  • E1-E4 to identify eyelids
MODIFIER 59
INAPPROPRIATE USES

• When submitted on E/M codes 99202-99499
• When a valid modifier exists to identify the services.
• When documentation does not support the separate and distinct status.
• When used to indicate multiple administration of injections of the same drug.
• When the NCCI tables lists the procedure code pair with a modifier indicator of "0".
Dr. Higgins removed a soft tissue tumor from a patient’s right forearm in the OR at Miami Surgical Center. During this same operative session, the physician also excised a benign lesion that measured 2.2 cm from the patient’s neck.

**Bill:** 25077, 11423-59

The physician sent surgical pathology to Circle Labs for microscopic review containing specimens from the spleen and a stomach biopsy as well.

**Bill:** 88305, 88305-59
MODIFIERS 76 AND 77

**Modifier 76: Repeat procedure or service by same physician or other QHP on the same day**

**Example:** chest x-ray taken in the morning which revealed pneumothorax was repeated and read by the same physician after the placement of a chest tube

**Bill:** 71045-26, 71045-26-76

**Modifier 77: Repeat procedure by another physician or other QHP on the same day**
MODIFIERS 76 AND 77

USAGE

• Use these for procedures that cannot be billed with more than one unit. (NCCI MUE edits)
• Typically used with x-ray and EKG procedures
• Use modifier 91 for repeat lab services
• Do not use:
  • staged procedures (58)
  • unplanned return to the OR (78)
  • unrelated procedure (79)
MODIFIERS 26 AND TC

Certain procedures are a combination of a professional component (supervision and interpretation) and a technical component (performance).

**Modifier 26**: indicates that the provider interpreted the test, but did not perform it

**Modifier TC**: indicates that the provider performed the test but did not interpret it

**No modifier** indicates that the provider performed both components (global)
Watch out for code description:

• Do not use if the procedure indicates that it is technical only, such as 93005 (ECG with at least 12 leads, tracing only, without interpretation and report)

• Do not use if procedure indicates professional component only, such as 93010 (routine ECG with at least 12 leads, interpretation and report only)

• Do not use if procedure indicated global test only, such as 93000 (routine ECG with at least 12 leads, with interpretation and report)
The principal surgeon oversees the patient’s case. Assistant surgeons may be necessary because the procedure or the patient’s condition is complex. The assistant surgeon performs under the direct supervision of the principal surgeon and is often in the same specialty as the principal surgeon.
80 Assistant Surgeon: surgical assistant services performed in a non-teaching setting or in a teaching setting when a resident was available, but the surgeon opted not to use the resident.

- Assists the principal surgeon during the entire procedure
81 Minimum Assistant Surgeon: Another surgeon is called in to assist for a limited time.

• Assists the principal surgeon during part of the procedure
82 Assistant Surgeon: surgical assistant services performed in teaching hospitals if there is no approved training program related to the medical specialty required for the surgical procedure or no qualified resident was available.

- Assists the principal surgeon during the entire procedure when a medical resident is not available to assist
MODIFIER AS

**AS**: Surgical assistant services performed by physician assistant, nurse practitioner, or clinical nurse specialist

- Used in addition to 80, 81, 82
The MPFS status indicators for assistant at surgery services should be used to determine if the procedure is allowed with the assistance of a second surgeon.

0 = Payment restrictions for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.

2 = Payment restrictions for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.
USAGE

• Other clinicians can assist with surgeries, but you should only use the Assistant Surgeon modifiers for procedures that physicians perform.

• Payers reimburse differently for assistant surgeons and minimum assistant surgeons, often paying a percentage of the total reimbursement amount for the procedure, with less paid to a minimum assistant surgeon than an assistant surgeon.

• The principal surgeon submits the procedure code for the surgery to the payer. The assistant surgeon submits the same procedure code with the appropriate assistant to surgery modifier.
MEDICARE USAGE

• Medicare will not pay assistant surgeons for surgical procedures that a provider assists with in fewer than five percent of the cases for the procedure nationwide.

• Providers cannot bill Medicare beneficiaries for balances remaining after Medicare reimburses for assistant surgeons.

• Medicare will not pay for an assistant surgeon when modifiers 62, Two Surgeons, or 66, Surgical Team, would be more appropriate.
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