# Modifiers

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| **What are they?** | Two digit numeric or alpha numeric character |
| **Why do we have them?** | AMA/CPT© Manual and CMS define Modifiers as "a means to report or indicate that a performed service/procedure has been altered by a specific circumstance but not changed its definition/code" |
| **Why use them?** | ✓Clarify services reported<br>✓Protect reimbursement<br>✓Help prevent claim delays<br>✓Help prevent claim denials and need for resubmission or appeal<br>✓Ensure proper reimbursement for services that vary from those normally reported |
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| **What AREN'T modifiers?** | ⃠Modifiers are not a guarantee of payment<br>⃠May not be viewed as a way to bypass payer edits<br>⃠May not be used as a way to navigate around coverage issues/guidelines<br>⃠Are not the 'magic bullet' to achieve payment |

| **Modifiers for E/M Codes** | | |
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| **24** | Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period | ▸ Unrelated E&M Service by same physician during the postop global period<br>▸ Added to E&M code only<br>▸ Link E&M service to new ICD-10 Dx<br>▸ Use for complications, unrelated Dx, exacerbations, recurrences, etc.<br>▸ For instance: You see and evaluate a patient for a new problem during the global period of a procedure performed by yourself or your partner |
| **25** | Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service | ▸ Significant, separately identifiable E&M service (same MD) on the same day of a minor procedure or other service<br>▸ Designed to protect the value of the E/M visit<br>▸ A minor procedure has a global period of 000 or 010 days. (e.g. injection/aspiration, biopsy, minor I&D, apply dressing or cast, perc vert aug)<br>▸ Any E/M service that is above and beyond the usual preoperative and postoperative care associated with the procedure.<br>▸ The critical issue is understanding the usual or typical E/M work performed prior to and after the procedure<br>▸ If the services provided in the E/M visit are more than this typical pre- and post-service work, they can be considered significant and separately reportable |
| **57** | Decision for Surgery | ▸ Decision for surgery modifier<br>▸ Applies to E&M code<br>▸ When decision for surgery made at the time of the E&M service (usually day of or day before)<br>▸ Allows payment for E&M service performed in the preoperative global period of the procedural service (e.g. 24 hrs for CMS)<br>▸ Use only if procedure is major (90 day global) |

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| **Complexity Modifiers** | | |
| **22** | Increased Procedural Services | ▸ When the work required to provide a service is substantially greater than typically required<br>▸ Documentation must support the substantial additional work and the reason for the additional work<br><br>What justifies use of the modifier?<br>•altered surgical field<br>•abnormal anatomy<br>•major scarring<br>•profuse bleeding<br>•morbid obesity |
| **52** | Reduced Services | ▸ Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion.<br>▸ Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced.<br><br>Example: Change the liner instead of a full revision hip |
| **Pre- and Post-Operative Care** | | |
| **54** | Surgical Care Only | •Intra-Op 69%<br>•Surgical procedure |
| **55** | Postoperative Management Only | •Post-op 21%<br>•Routine post-op care for 1st 90 days |
| **56** | Preoperative Management Only | •Preop 10%<br>•Services the day before and day of surgery |
| **Same Day Procedures** | | |
| **50** | Bilateral Procedure | •Bilateral procedure modifier when the same procedure performed on both sides at same operative setting<br>•Applies to limited codes (see AMA publication RBRVS, A Physician's Guide)<br>•Don't Apply Modifiers to codes which are unilateral or bilateral.<br>•Either line item or single line with 2 units<br>•Expect 50% reduction in allowable for 2nd side |
| **51** | Multiple Procedures | •Multiple procedure modifier<br>•Applies to stand-alone codes only<br>•Add-on codes do not need the modifier<br>•Code procedure with highest RVU first (without modifier), -51 appended to second, third, etc.<br>•Customary reimbursement 100%, 50%, 25%, etc. |
| **59** | Distinct Procedural Service | •Distinct different procedure on the same day:<br>▸ different session or patient encounter<br>▸ separate incision/ excision<br>▸ different procedure or surgery<br>▸ separate lesion |

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| | | ▸ different site or organ system<br>▸ separate injury<br>•Reduction based on concurrent modifier (-51)<br>•Should not be used when CCI edit disallows additional procedures at the same location |
| **76** | Repeat Procedure or Service by Same Physician or Other QHP | •Repeat procedure by same provider<br>•Medicare considers two physicians, in the same group with the same specialty as the same physician<br>•Needs to be exact same procedure / CPT code<br>•Append to second procedure<br>•Should be used for procedures which cannot be quantity billed.<br>•Not planned but not necessarily a complication, eg. repeat disc excision |
| **77** | Repeat Procedure by Another Physician or Other Qualified Health Care Professional | •Repeat procedure by another surgeon<br>•Added during global period<br>•Same circumstances as 76<br>• e.g. Recurrent or persistent disc displacement requiring 63030 again less than 90 days after initial procedure<br>•Expect NO reduction for overlapping globals |

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| | **New Procedure in the Global Period** | |
| **58** | Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period | • Use with staged procedure when you know pt will return for subsequent surgery<br>• Document intention in initial OR note<br>• Resets global period clock<br>• Don't use for complications requiring return to OR (78 modifier)<br>Present procedure is more extensive than the prior procedure.<br>Therapy following a diagnostic surgical procedure<br>Doesn't apply to add-on codes<br>• Shouldn't affect reimbursement |
| **78** | Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period | • The complication modifier<br>• Unplanned return to the OR during the post op period<br>• Used for postoperative complications within the global period, eg. hematoma<br>• Bill full fee, but only intraop services are reimbursed<br>• Expect reimbursement reduction for complication<br>• Global period is not reset |
| **79** | Unrelated Procedure or Service by the Same Physician or | • New problem during the post op period which requires a procedure e.g. Carpal Tunnel Release 2 months after ACDF<br>• Use new ICD-10 diagnostic codes (different from original procedure) |

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| | Other Qualified Health Care Professional During the Postoperative Period | • Expect NO reduction for overlapping globals<br>• Expect full payment for 2nd procedure |
| **Physician's Role at Surgery** | | |
| **80** | Assistant Surgeon | 80% of the time, Expect 16-25% of allowable |
| **81** | Minimum Assistant Surgeon | Less than 80% of the time<br>(Don't expect much, maybe 10% of surgeon's fee) |
| **82** | Assistant Surgeon (when qualified resident surgeon not available) | Summer Vacation in a teaching facility |
| **AS** | Assist by PA or NP | Assist by PA or NP, pays 15% less than physician allowable |
| **Multiple Surgeons** | | |
| **62** | Two Surgeons | e.g. Spine and General or Vascular |
| **66** | Surgical Team | Epic procedures, Replants or Transplants |
| **Miscellaneous Modifiers** | | |
| **26** | Professional Component | e.g. professional interpretation of x-rays |
| **53** | Discontinued Procedure | |
| **GC** | Teaching Hospital | |