

Understanding Modifiers

Comprehensive instruction to effective
modifier application

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Introduction

For many years, physicians and hospitals have learned that coding and billing are inextricably entwined processes. Coding provides the common language through which the physician and hospital can communicate—or bill—their services to third-party payers, including managed care organizations, the federal Medicare program, and state Medicaid programs.

The use of modifiers is an important part of coding and billing for health care services. Modifier use has increased as various commercial payers, who in the past did not incorporate modifiers into their reimbursement protocol, recognize and accept HCPCS codes appended with these specialized billing flags.

Correct modifier use is also an important part of avoiding fraud and abuse or noncompliance issues, especially in coding and billing processes involving the federal and state governments. One of the top 10 billing errors determined by federal, state, and private payers involves the incorrect use of modifiers.

WHAT ARE HCPCS MODIFIERS?

A modifier comprises two alpha, numeric, or alphanumeric characters reported with a HCPCS code, when appropriate.

Modifiers are designed to give Medicare and commercial payers additional information needed to process a claim. This includes HCPCS Level I (Physicians' Current Procedural Terminology [CPT[®]]) and HCPCS Level II codes.

The reporting physician appends a modifier to indicate special circumstances that affect the service provided without affecting the service or procedure description itself. When applicable, the appropriate two-character modifier code should be used to identify the modifying circumstance. The modifier should be placed after the usual procedure code number.

The CPT code book, *CPT 2021*, lists the following examples of when a modifier may be appropriate, including, but not limited to:

- Service/procedure is a global service comprising both a professional and technical component and only a single component is being reported
- Service/procedure involves more than a single provider and/or multiple locations
- Service /procedure was either more involved or did not require the degree of work specified in the code descriptor
- Service/procedure entailed completion of only a segment of the total service/procedure
- An extra or additional service was provided
- Service/procedure was performed on a mirror image body part (eyes, extremities, kidneys, lungs) and not unilaterally
- Service/procedure was repeated



IMPORTANT

At the time of printing, the 2021 alphanumeric HCPCS file had not been posted by the Centers for Medicare and Medicaid Services (CMS). Once released, the 2021 HCPCS codes will be available on our products update page at: <https://www.optum360coding.com/ProductUpdates/>.



FOR MORE INFO

See chapter 13, "Modifiers and Compliance," for more details on fraud and abuse.

Chapter 1: E/M-Related Modifiers 24, 25, 57, and AI

Modifiers 24, 25, 57, and AI may be appended to evaluation and management services only. Each modifier is listed below with its official definition and an example of appropriate use.

24 Unrelated Evaluation and Management Service by the Same Physician Or Other Qualified Health Care Professional During a Postoperative Period

The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

Modifier 24 is added to the selected E/M service code to identify the E/M service rendered by the same provider as separate and distinct from other services in the patient's postoperative period.

Example:

A patient who is 45 days status post for a cholecystectomy presents to the same physician for evaluation of pain and bleeding associated with hemorrhoids. The physician performs a level 2 office visit and appends modifier 24 to indicate that today's visit is unrelated to the patient's prior cholecystectomy.

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

It may be necessary to indicate that on the day a procedure or service identified by a CPT® code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Note: This modifier is not used to report an E/M service that resulted in a decision to perform major surgery, see modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

Modifier 25 is used to identify an E/M service rendered on the same day as a procedure or service by the same physician or other qualified health care

Chapter 2:

Anesthesia-Related Modifiers

Modifiers 23 and 47, modifiers describing physical status (P1, P2, P3, P4, P5, and P6), and HCPCS Level II modifiers AA, AD, G8, G9, QK, QS, QX, QY, and QZ may be appended only to identify anesthesia services. Each modifier is listed below with its official definition and an example of appropriate use.

ANESTHESIA SERVICES MODIFIERS 23 AND 47

23 Unusual Anesthesia

Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

Modifier 23 is reported only with anesthesia service codes to identify those circumstances in which monitored or general anesthesia is required in addition to the usual service.

Example:

A 2-year-old child is brought to the emergency room with a severe leg laceration covered in gravel and dirt that resulted from falling off of his tricycle and onto asphalt and dirt. The patient is extremely agitated, scared, crying, and uncontrollable. Due to the patient's age and the significant stress being placed on the child, the emergency physician advises the parents that the use of a general anesthesia is necessary to adequately debride and suture the complex wound. The anesthesiologist is consulted and the procedure performed. The anesthesiologist will append modifier 23 to the appropriate anesthesia code to indicate the unusual circumstances necessitating the use of general anesthesia. The surgeon will report the correct debridement and/or repair codes.

47 Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures.

Modifier 47 should be reported with a code from the surgery section of the CPT® book when the surgeon performing the specific procedure is also administering a regional or general anesthesia.

Example:

An adolescent patient presents to the physician's operating room with a fracture to the wrist. The surgeon evaluates the patient and performs a separate anesthesia H&P to determine any potential contraindications to anesthesia. After informed consent, the patient is prepped and draped in the usual sterile manner. The surgeon administers a Bier block and has the PA monitor the patient. The PA documents that the patient's vital signs are



KEY POINT

Claims submitted to Medicare, Medicaid, and other third-party payers containing modifier 23 for unusual anesthesia must have attached supporting documentation submitted with the claim. When documentation is not submitted, the claim is processed as if no modifier had been appended to the service code. In some cases, the insurance payer may suspend the claim and request additional information; however this is the exception rather than the rule.

Chapter 3: Mandated and Preventive Services-Related Modifiers 32 and 33

Modifiers 32 and 33 are used in very specific circumstances dictated by law. For example, modifier 32 indicates that the service being provided has been mandated—that is, formally ordered by a court or other superior official or payer. In the case of modifier 33 (Preventive service), it may be necessary to identify for insurance companies those preventive services that require all health insurance plans to cover preventive services and immunizations without any associated cost sharing for that particular service as the result of health care reform regulations. Each modifier is listed below with its official definition and an example of appropriate use.

32 Mandated Service

Services related to *mandated* consultation and/or related service (e.g., third party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

Modifier 32 is appended to the appropriate code to designate those services that have been formally ordered by an appropriate agency or organization for a specified purpose.

Example:

The unmarried parents of a 3-month-old female infant are ordered by the court to undergo DNA testing to determine paternity and establish court-ordered visitation and child support as appropriate. The laboratory performing the testing would report the service and append modifier 32 to indicate that the testing is being conducted at the court's request.

33 Preventive Service

When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force (USPSTF) A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending modifier 33, Preventive Service, to the service. For separately reportable services specifically identified as preventive, the modifier should not be used.

This modifier should be reported with codes that represent preventive services with the exception of those codes that are inherently preventive such as a screening mammography or an immunization recognized by the Advisory Committee on Immunization Practices (ACIP).

Example:

A 67-year-old male patient presents to the office for his annual physical examination and during the course of the encounter, the provider recommends a one-time screening for an abdominal aortic aneurysm (AAA)

Chapter 4:

Procedures/Services Modifiers

The modifiers discussed within this chapter may be appended to codes from the anesthesia, surgery, radiology, pathology/laboratory, and medicine sections of the CPT® manual. For ease of use and understanding, the chapter is subdivided into five categories according to specific groupings of modifiers as shown below:

- Increased procedural services modifier 22
- Bilateral, multiple, reduced, discontinued, and distinct procedures or services modifiers 50, 51, 52, 53, 59, XE, XP, XS, and XU
- Global component modifiers 54, 55, and 56
- Postoperative procedures or services modifiers 58, 78, and 79
- Repeat procedures or services modifiers 76 and 77

Note: In the interest of maintaining all modifiers within their specific chapter and category, modifiers approved for hospital outpatient use (50, 52, 58, 59, 76, 77, 78, and 79) will also contain coding guidance and tips specific to the ambulatory surgery center (ASC) and hospital outpatient settings rather than repeating the modifier in the ASC and outpatient chapter. However, for information on ASC and hospital outpatient only modifiers 27, 73, and 74, see chapter 12 on ASC/outpatient modifiers.

INCREASED PROCEDURAL SERVICES MODIFIER 22

Modifier 22 indicates that the procedure or service performed required significantly greater effort and work than what would usually be involved. As stated earlier, it may be reported with any code from the anesthesia, surgery, radiology, pathology/laboratory, and medicine sections of the CPT book. However, it is not appropriate to report modifier 22 with an evaluation and management service code.

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

Modifier 22 is appended to the procedure or service code that warranted the increased effort and should typically be submitted with a narrative detailing the specific increased work and complexity that necessitated the use of this modifier.

Example:

A patient is scheduled for repair of a small bowel obstruction. The patient is prepped and draped and taken to the operating room. The physician begins



QUICK TIP

Hospital ASC and Outpatient Coders

Modifier 22 is not applicable in ASCs or hospital outpatient facilities in accordance with CPT modifiers approved for ASC outpatient hospital use.



KEY POINT

Claims submitted to Medicare, Medicaid, and other third-party payers containing modifier 22 Increased procedural services, that do not have supporting documentation attached to the claim demonstrating the increased effort involved will generally be processed as if the procedure code(s) did not contain the modifier. Some third-party payers may suspend the claims pending a request for additional information; however, this is typically the exception and not the rule.

Chapter 5: Multiple Surgeon Modifiers: 62 and 66

Modifiers 62 and 66 represent multiple surgeons and may be appended to procedure codes to indicate that the service required the need for more than one surgeon functioning in different capacities. Each modifier is listed below with its official definition and an example of appropriate use.

62 Two Surgeons

When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the cosurgery once using the same procedure code. If additional procedure(s), (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a cosurgeon acts as an assistant in the performance of additional procedure(s) other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

Modifier 62 is appended to the appropriate service code when two surgeons both function as primary surgeons performing independent components of the same procedure.

Example:

A patient undergoes an anterior lumbar spinal fusion of L5 through S1 involving cages and bone grafts. A general surgeon and a spine surgeon work together as cosurgeons; the general surgeon performs the surgical approach, and the orthopaedic surgeon performs the fusion. Each surgeon would report the same CPT® codes and append modifier 62 to each of the service codes assigned to indicate that each physician performed a distinct component of the same operative procedure.



QUICK TIP

Hospital ASC and Outpatient Coders

Modifiers 62 and 66 are not applicable in hospital ASC or hospital outpatient facilities in accordance with CPT modifiers approved for ambulatory surgery center (ASC) outpatient hospital use.

Chapter 7:

Professional/Technical Component Modifiers 26 and TC

Modifiers 26 and TC represent distinct components of a global procedure or service. When the physician component is reported separately, the service may be identified by appending modifier 26 to the usual procedure code. Similarly, when the technical component is reported separately, modifier TC should be reported with the usual procedure code. Each modifier is listed below with its official definition and an example of appropriate use.

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

Modifier 26 should be used when the physician or nonphysician provider is rendering only the professional component of a global procedure or service code. This modifier is never reported on evaluation and management service codes.

Example:

A computed tomography (CT) including pre films, administration of contrast, and post films of both the abdomen and pelvis was performed in the outpatient hospital department. Report code 74178 with modifier 26 to denote physician services only.

TC Technical Component

Under certain circumstances, a charge may be made for the technical component alone. In those cases, the technical component charge is identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and are not billed separately by physicians. However, portable x-ray suppliers bill only for the technical component and should use modifier TC. The charge data from portable x-ray suppliers is then used to build customary and prevailing profiles.

Modifier TC should be used to report only the technical component of a global procedure or service code. Remember, typically the technical component is provided by the facility or mobile x-ray unit. This modifier is never reported on evaluation and management service codes.

Example:

A unilateral pulmonary angiogram radiological supervision and interpretation is performed in an outpatient hospital setting. Report code 75741 with modifier TC to identify the facility's services.



KEY POINT

Certain procedure codes describe and represent only the professional component portion of a procedure or service and are stand-alone procedure or service codes, identifying the physician's or provider's professional efforts. In most cases, other procedure or service codes identify the technical component only, and codes that represent both the professional and technical components as complete procedures or services are called global service codes. It is not necessary to report modifier 26 with codes that aptly describe and represent only the professional component of a procedure or service.

Chapter 11: HCPCS Level II Modifiers A–Z

INTRODUCTION

The HCPCS Level II codes are alphanumeric codes developed by the Centers for Medicare and Medicaid Services as a complementary coding system to the AMA's CPT® codes. HCPCS Level II codes describe procedures, services, and supplies not found in the CPT book.

Similar to the CPT coding system, HCPCS Level II codes also contain modifiers that further define services and items without changing the basic meaning of the CPT or HCPCS Level II code with which they are reported. However, the HCPCS Level II modifiers differ somewhat from their CPT counterparts in that they are composed of either alpha characters or alphanumeric characters. HCPCS Level II modifiers range from A1 to XU and include such diverse modifiers as E1 Upper left, eyelid, GJ "Opt out" physician or practitioner emergency or urgent service, and Q6 Service furnished under a fee-for-time compensation arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area.

It is important to note that HCPCS Level II modifiers may be used in conjunction with CPT codes, such as 69436-LT Tympanostomy (requiring insertion of ventilating tube), general anesthesia, left ear. Likewise, CPT modifiers can be used when reporting HCPCS Level II codes, such as L4396-50. Ankle contracture splint, bilateral (this scenario can also be reported with modifiers RT and LT, depending on the third-party payer's protocol). In some cases, a report may be required to accompany the claim to support the need for a particular modifier's use, especially when the presence of a modifier causes suspension of the claim for manual review and pricing.

AMBULANCE MODIFIERS

For ambulance services modifiers, single alpha characters with distinct definitions are paired to form a two-character modifier. The first character indicates the origination of the patient (e.g., patient's home, physician office, etc.), and the second character indicates the destination of the patient (e.g., hospital, skilled nursing facility, etc.). When ambulance services are reported, the name of the hospital or facility should be included on the claim. If reporting the scene of an accident or acute event (character S) as the origin of the patient, a written description of the actual location of the scene or event must be included with the claim(s).

- D Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes
- E Residential, domiciliary, custodial facility (other than 1819 facility)



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<https://www.optum360coding.com/ProductUpdates/>.

Chapter 12: ASC and Hospital Outpatient Modifiers: 25, 27, 73, and 74

AMBULATORY PAYMENT CLASSIFICATIONS

Since the implementation of Medicare's outpatient prospective payment system (OPPS), effective August 1, 2000, hospital outpatient services including hospital-based ambulatory surgery, and provider-based clinics have been reimbursed under ambulatory payment classifications (APCs). The formulation of the APC grouping system took root in the ambulatory patient groups (APGs) system, devised by the Health Information Systems division of 3M Health Care under a grant from the Centers for Medicare and Medicaid Services (CMS). The APC reimbursement system for surgical procedures and other services, however, is not the same as the APG system (still in use by some payers).

The incorporation of APCs into each facility's internal coding and billing systems as well as clinical operations represents an enormous challenge. It is generally agreed that this system of reimbursement requires greater attention to operational economies and the creation of increased internal efficiencies when compared with the past implementation of the diagnosis-related group (DRG) system of reimbursement for the hospital inpatient arena.

CPT® and certain HCPCS Level II codes map to a particular APC classification that holds a predefined reimbursement amount. The financial welfare of any facility outpatient (OP) department, OP clinic, hospital ASC, freestanding ASC, or private physician practice has always depended on the accurate coding and reporting of services. Now, with reimbursement for some of these health care centers based on the APC system of reimbursement, accurately coding and reporting services have never been more critical. A few simple facts about APCs include the following:

- APCs are groups of services with homogeneous or nearly identical clinical characteristics as well as costs.
- At this time, APCs affect only hospital OP department/clinic and hospital-based ambulatory surgery payment for Medicare patients. (Freestanding ASCs are paid under a different payment system.)
- Physician payments are not affected.
- The APC payment system is correlated to CPT and certain HCPCS Level II codes.
- Many CPT and HCPCS Level II codes map to an APC payment group.
- The encounter date for each patient may include one or more APC services.

The use of modifiers has proven a crucial component to Medicare's appropriate and optimal reimbursement of services under APCs. Modifiers are addressed in

KEY POINT

Not all third-party payers use the APC system of reimbursement for provider-based ASC and hospital outpatient facility services. There are several major third-party payers currently using—and seemingly satisfied with—the APG system of reimbursement for facility services.

Modifier 50

