

Guide to Modifiers

Hospital Outpatient Edition



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Susan E. Garrison, CHCA, CPC, CPC-H

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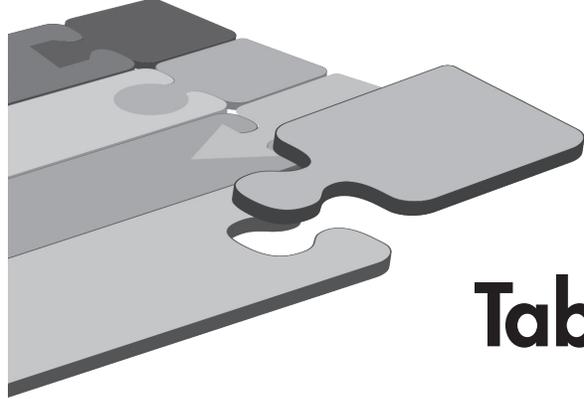
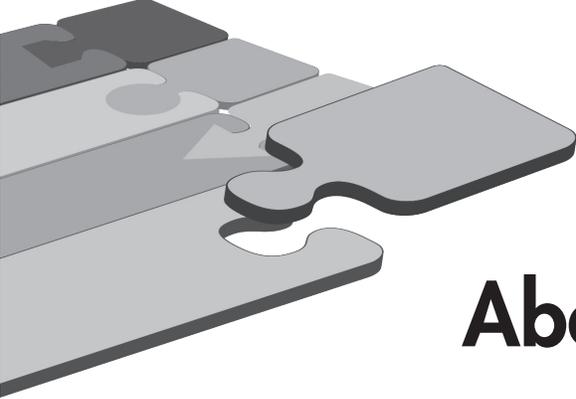


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About the Author

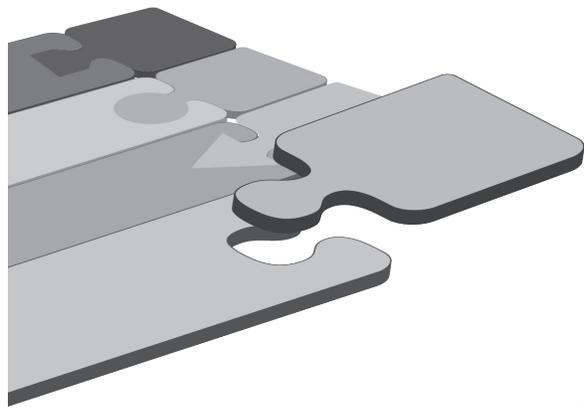
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Susan Garrison, CHCA, CHC, PCS, FCS, CPC, CCS-P, CPAR, CPC-H, serves as executive vice president of both Med Law Advisors and the healthcare consulting division of Magnus Confidential, Inc. (Med Law Advisors' parent company). She is also executive director of the Association of Health Care Auditors and Educators (AHCAE), an international professional membership organization.

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Chapter 1

Introduction

Background

Modifiers provide a way to indicate that a service or procedure has been altered by some specific circumstance but has not changed in definition or code. They are intended to communicate specific information that is not contained in the code definition itself.

Some of the changes that modifiers can communicate include the following:

- A service was increased
- A procedure was performed on one side or the other, or bilaterally
- A second procedure was a distinct but repeated procedure, rather than a duplicate
- A medical visit is distinct from a procedure performed on the same date
- Only part of the intended service or procedure could be performed
- To delineate a circumstance in which a patient received multiple evaluation and management (E/M) services in multiple outpatient hospital settings
- An adjunctive service was performed
- A service or procedure was provided more than once
- A service or procedure was planned prospectively at the time of the original procedure
- Unusual events occurred (e.g., procedure terminated due to alteration in patient's physiologic status)

Consider the following guidelines:

- More than one modifier can be attached to a procedure code, when applicable.
- Not all modifiers can be used with all procedure codes.
- Modifiers do not ensure reimbursement. Some modifiers affect reimbursement by increasing or decreasing amounts; others are only informational.

Current Procedural Terminology® (CPT) or Healthcare Common Procedure Coding System (HCPCS) Level II codes can have modifiers appended. Essentially, the modifiers will limit, expand, or otherwise qualify a CPT/HCPCS code. The modifier is a two-character code appended to the end of the CPT/HCPCS code.

Example

- Primary coding, CPT 29881 represents a knee arthroscopy with meniscectomy
- Modified coding, CPT 29881-LT
 - The modifier -LT (left) clarifies that the arthroscopy was performed on the left knee

Example

- Primary coding, CPT 45380 represents a colonoscopy with biopsy, CPT 45385 represents a colonoscopy with snare polypectomy
- Modified coding, CPT 45380-XS, CPT 45385
 - The modifier -XS (separate structure) clarifies that the biopsy was of a different site than the snare polypectomy

As with any coding, modifiers should be used only when the medical record documentation clearly supports them. This is especially important because modifiers often affect the CPT/HCPCS code level of reimbursement.

As illustrated above, modifiers are two-digit codes that are categorized into two levels:

- Level I modifiers are numeric CPT modifiers maintained by the American Medical Association
- Level II modifiers are alphanumeric HCPCS modifiers maintained by the Centers for Medicare & Medicaid Services (CMS)

CPT coding tip

For hospital outpatient reporting, the “postoperative period” in the language of some modifiers (e.g., -58, -78, and -79) is confusing, since hospital outpatient reporting represents services performed in a given 24-hour period or on a range of dates. Note that, for outpatient hospital reporting, these modifiers would apply only when the second procedure occurs on the same date of service.

It is not appropriate to append modifiers to unlisted CPT procedure codes because they do not describe *specific* procedures. Instead, when reporting an unlisted code to describe a procedure or service, submit supporting documentation (e.g., a procedure report) that provides an adequate description of the nature, extent, and need for the procedure, time, effort, and equipment in providing the service.¹

CMS requires hospitals to report the following modifiers (when appropriate) for Medicare outpatient services:^{2,3}

- -25, significant, separately identifiable evaluation and management (E/M) service by the same physician on the same day as the procedure or other service
- -27, multiple outpatient hospital E/M encounters on the same date
- -50, bilateral procedure
- -52, reduced services
- -58, stage or related procedure
- -59, distinct procedural service
- -73, discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to administration of anesthesia
- -74, discontinued outpatient hospital/ASC procedure after the administration of anesthesia
- -76, repeat procedure by same physician
- -77, repeat procedure by another physician
- -91, repeat clinical diagnostic laboratory tests
- -CA, procedure payable only in the inpatient setting when performed in an emergency on an outpatient who dies prior to admission
- -E1, upper left, eyelid
- -E2, lower left, eyelid
- -E3, upper right, eyelid
- -E4, lower right, eyelid
- -FA, left hand, thumb
- -F1, left hand, second digit
- -F2, left hand, third digit
- -F3, left hand, fourth digit
- -F4, left hand, fifth digit
- -F5, right hand, thumb
- -F6, right hand, second digit
- -F7, right hand, third digit
- -F8, right hand, fourth digit

- -F9, right hand, fifth digit
- -GA, required Waiver of Liability (ABN) issued
- -GG, performance and payment of a screening mammogram and a diagnostic mammogram on the same patient, same day
- -GH, diagnostic mammogram converted from screening mammogram on same day
- -GN, service delivered personally by a speech-language pathologist or under an outpatient speech-language pathology plan of care
- -GO, service delivered personally by an occupational therapist or under an outpatient occupational therapy plan of care
- -GP, service delivered personally by physical therapist or under an outpatient physical therapy plan of care
- -GX, voluntary Waiver of Liability (ABN) on file
- -GY, item or service statutorily excluded or does not meet the definition of any Medicare benefit
- -GZ, item or service expected to be denied as not reasonable and necessary
- -L1, lab to be reimbursed under the clinical lab fee schedule for non-patients
- -LC, left circumflex coronary artery (for CPT codes 92980–92982, 92995, and 92996)
- -LD, left anterior descending coronary (for CPT codes 92980–92982, 92995, and 92996)
- -LM, left main coronary artery (for CPT codes 92980–92982, 92995, and 92996)
- -LT, left side
- -QL, patient pronounced dead after ambulance called
- -QM, ambulance service provided under arrangement by a provider of services
- -QN, ambulance service furnished directly by a provider of services
- -RC, right coronary artery (for CPT codes 92980–92982, 92995, and 92996)
- -RI, ramus intermedius coronary artery (for CPT codes 92980–92982, 92995, and 92996)
- -RT, right side
- -TA, left foot, great toe
- -T1, left foot, second digit
- -T2, left foot, third digit
- -T3, left foot, fourth digit
- -T4, left foot, fifth digit
- -T5, right foot, great toe
- -T6, right foot, second digit
- -T7, right foot, third digit
- -T8, right foot, fourth digit

- -T9, right foot, fifth digit
- -XE, separate encounter
- -XS, separate structure
- -XP, separate practitioner
- -XU, unusual non-overlapping service

The following chapters will provide official modifier reporting guidelines, case studies, and exercises for each of the modifiers required for Medicare hospital outpatient reporting. Questions to ask before applying a modifier to a HCPCS/CPT code include the following:

- Will the modifier add more information regarding the anatomic site of the procedure?
Example: Cataract surgery on the right or left eye.
- Will the modifier help to eliminate the appearance of duplicate billing?
Example: Use modifier -77 to report the same procedure performed more than once on the same date of service.
- Will the modifier help drive appropriate reimbursement when bundling edits exist?
Example: Use modifier -78 to indicate that the patient had to return to the operating room to address a complication from a procedure performed earlier in the day.

References

1. CPT Assistant, American Medical Association, Chicago, IL, February 2002 and December 2011.
2. “Medicare Claims Processing Manual: Chapter 4—Part B Hospital,” Centers for Medicare & Medicaid Services, accessed September 4, 2015, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf>.
3. “MLN Matters,” Centers for Medicare & Medicaid Services, accessed September 4, 2015, <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6563.pdf>.

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Modifiers are a frequent audit target of CMS and the Office of Inspector General, with focused efforts against modifiers such as -25 and -59. ***JustCoding's Guide to Modifiers: Hospital Outpatient Edition*** features a comprehensive explanation of when to append each CPT®/HCPCS modifier, including coding tips and the latest regulations and guidance. Each chapter contains exercises that let you use real-life documentation, including operative reports and case studies, to test your knowledge on how to apply each modifier.

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