

Modifiers

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?	<ul style="list-style-type: none">✓ Clarify services reported✓ Protect reimbursement✓ Help prevent claim delays✓ Help prevent claim denials and need for resubmission or appeal✓ Ensure proper reimbursement for services that vary from those normally reported
What AREN'T modifiers?	<ul style="list-style-type: none">⊗ They are not a guarantee of payment⊗ They are not a way to bypass payer edits⊗ They are not a way to navigate around coverage issues/guidelines⊗ They are not the “magic bullet” to achieve payment

Modifiers for E/M Codes

<p>24</p>	<p>Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional (QHP) During a Postoperative Period</p>	<ul style="list-style-type: none"> • Unrelated E&M Service by same physician during the postop global period • Added to E&M code only • Link E&M service to new ICD-10 Dx • Use for complications, unrelated Dx, exacerbations, recurrences, etc. • 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
<p>25</p>	<p>Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other QHP on the Same Day of the Procedure or Other Service</p>	<ul style="list-style-type: none"> • Significant, separately identifiable E&M service (same MD) on the same day of a minor procedure or other service • Designed to protect the value of the E/M visit • 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) • Any E/M service that is above and beyond the usual preoperative and postoperative care associated with the procedure • The critical issue is understanding the usual or typical E/M work performed prior to and after the procedure • 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
<p>57</p>	<p>Decision for Surgery</p>	<ul style="list-style-type: none"> • Decision for surgery modifier • Applies to E&M code • When decision for surgery made at the time of the E&M service (usually day of or day before) • Allows payment for E&M service performed in the preoperative global period of the procedural service (e.g., 24 hrs for CMS) • Use only if procedure is major (90-day global)

Complexity Modifiers

22	Increased Procedural Services	<ul style="list-style-type: none"> • When the work required to provide a service is substantially greater than typically required • Documentation must support the substantial additional work and the reason for the additional work <p>What justifies use of the modifier?</p> <ul style="list-style-type: none"> • altered surgical field • abnormal anatomy • major scarring • profuse bleeding • morbid obesity
52	Reduced Services	<ul style="list-style-type: none"> • Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's discretion • 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 <p>Example: Change the liner instead of a full revision hip</p>

Pre- and Post-Operative Care

54	Surgical Care Only	<ul style="list-style-type: none"> • Intra-Op 69% • Surgical procedure
55	Postoperative Management Only	<ul style="list-style-type: none"> • Post-op 21% • Routine post-op care for 1st 90 days
56	Preoperative Management Only	<ul style="list-style-type: none"> • Pre-op 10% • Services the day before and day of surgery

Same Day Procedures

50	Bilateral Procedure	<ul style="list-style-type: none"> • Bilateral procedure modifier when the same procedure performed on both sides at same operative setting • Applies to limited codes (see AMA publication RBRVS, A Physician's Guide) • Don't apply modifiers to codes which are unilateral or bilateral • Either line item or single line with 2 units • Expect 50% reduction in allowable for 2nd side
51	Multiple Procedures	<ul style="list-style-type: none"> • Multiple procedure modifier • Applies to stand-alone codes only • Add-on codes do not need the modifier • Code procedure with highest RVU first (without modifier), -51 appended to second, third, etc. • Customary reimbursement: 100%, 50%, 25%, etc.
59	Distinct Procedural Service	<ul style="list-style-type: none"> • Distinct different procedure on the same day: <ul style="list-style-type: none"> · different session or patient encounter · separate incision/excision · different procedure or surgery · separate lesion · different site or organ system · separate injury • Reduction based on concurrent modifier (-51) • 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	<ul style="list-style-type: none"> • Repeat procedure by same provider • Medicare considers two physicians in the same group with the same specialty as the same physician • Needs to be exact same procedure/CPT code • Append to second procedure • Should be used for procedures which cannot be quantity billed • Not planned but not necessarily a complication, (e.g., repeat disc excision)
77	Repeat Procedure by Another Physician or Other QHP	<ul style="list-style-type: none"> • Repeat procedure by another surgeon • Added during global period • Same circumstances as 76 <ul style="list-style-type: none"> · e.g., recurrent or persistent disc displacement requiring 63030 again less than 90 days after initial procedure • Expect NO reduction for overlapping globals

New Procedure in the Global Period

58	Staged or Related Procedure or Service by the Same Physician or Other QHP During the Postoperative Period	<ul style="list-style-type: none"> • Use with staged procedure when you know patient will return for subsequent surgery • Document intention in initial OR note • Resets global period clock • Don't use for complications requiring return to OR (78 modifier) • Present procedure is more extensive than the prior procedure • Therapy following a diagnostic surgical procedure • Doesn't apply to add-on codes • Shouldn't affect reimbursement
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other QHP Following Initial Procedure for a Related Procedure During the Postoperative Period	<ul style="list-style-type: none"> • The complication modifier • Unplanned return to the OR during the post-op period • Used for postoperative complications within the global period, (e.g., hematoma) • Bill full fee, but only intra-op services are reimbursed • Expect reimbursement reduction for complication • Global period is not reset
79	Unrelated Procedure or Service by the Same Physician or Other QHP During the Postoperative	<ul style="list-style-type: none"> • New problem during the post-op period which requires a procedure <ul style="list-style-type: none"> • e.g., Carpal Tunnel Release 2 months after ACDF • Use new ICD-10 diagnostic codes (different from original procedure) • Expect NO reduction for overlapping globals • 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 (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	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	