

Office of University Compliance



**SAINT LOUIS
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Clarification of Commonly Used Modifiers
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What is a Modifier?

A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities.

Modifier 24 Unrelated E/M Service

Unrelated E/M service by the SAME provider during a postoperative period

Problem/DX absolutely unrelated to original procedure

Not a complication of the procedure

What if there is a complication?

The modifier would be appended to the E/M code when the physician sees a patient for significant complications of the surgery (i.e. post-operative infection or persistent bleeding where a coagulopathy must be explored, linked to the appropriate diagnosis code to indicate the reason) **or** for an E/M visit completely unrelated to the surgery (i.e. ear infection)

Modifier 25

Significant, separately identifiable E/M service by same provider on the same day of procedure/other service

Generally, separate payment is not made for E/M Services performed on the same day as minor surgery

- Because it is expected that most procedures involve some pre-procedure and post-procedure care that is part of the payment for the procedure
- Condition requires a significant amount of pre/postoperative work
- Condition is separate from the procedure

Modifier 25

However, if a provider performs an E/M service on the same day as a procedure that is significant, separately identifiable, and above and beyond the usual pre-procedure and post-procedure care associated with the procedure, Modifier 25 should be used to allow additional payment for the separate E/M service

Used when the E/M Service is separate and significant from another service provided on the same day that has a global period of 0 to 10 days or services with “XXX” as the global period

Documentation must support that the service was separate and significant

Separate diagnosis not required

Modifier 25 “Significant”

Is the E/M service part of standard of care?

- When the E/M service is part of standard of care for the procedure, you cannot separately bill for the E/M
- However, if the physician documented a complete examination of an area not related to the procedure you might be able to justify a separate E/M level

If you subtracted the procedure from the scenario, is there enough documentation in the medical record to support an E/M level?

The separate E/M service should be extensive enough to warrant the reporting of a problem-based E/M code

Modifier 57

Decision for Surgery

- Represents the initial decision for surgery
- Only used for decision of major surgery on the day of or day before surgery
- In this case, the surgery is understood to be a major operative procedure, rather than a minor surgical procedure

Global Surgery Package

There are three types of global surgical packages based on the number of post-operative days:

Major, Minor, & Zero Days

Global Surgery: Major

90-day Post Operative Period

One day pre-operative included

Day of the procedure is generally not payable as a separate service

Total global period is 92 days

Count 1 day before the day of the surgery, the day of the surgery, and the 90 days immediately following the day of surgery or procedure

Global Surgery: Minor

10 days

No pre-operative period

Visit on day of the procedure is generally not payable as a separate service

Total global period is 11 days

Count the day of the surgery and 10 days following the day of the surgery

Global Surgery: Zero Days

0 days

Endoscopies and some minor procedures

No pre-operative & no post-operative days

Visit on day of procedure is generally not payable as a separate service

Post Op Periods

Medicare Physician Fee Schedule Look up tool provides the post op period for each procedure code.

<https://www.cms.gov/apps/physician-fee-schedule/overview.aspx>

Modifier 22 Increased Procedural Service

When the work required to provide the reported service is substantially greater than normally required

Increased intensity

More time spent

Technically challenging

Severity of condition

Physical or mental effort put forth by provider

Modifier 22

Special circumstances must RESULT in an ACTUAL INCREASE in time, complexity, or effort

Never used on E/M services

Almost always requires attachments:

Letter with brief synopsis of procedure and it's challenges and a requested increase in reimbursement

OP Note

Modifier 50: Bilateral Procedure

Bilateral being defined by a mirror image of the body

Right knee – Left knee

Right kidney – Left kidney

Bilateral procedures performed at the same session/service

Do NOT use this modifier when:

CPT descriptors already defines the code as bilateral

Modifier 52- Reduced Services

Service was partially reduced or eliminated at the discretion of the provider

Surgeries for which services performed are significantly less than usually required are billable with modifier 52

Decision that part of the procedure would be “left out” often made before surgery

Typically, payer will require OP note be submitted as well as a letter explaining the reduction of services and the reduction in payment you are expecting

Modifier 53 – Discontinued Procedure

Aborted surgical case/procedure

Circumstances threaten the well-being of the patient

Anatomical challenges

Extenuating circumstances

Patient discomfort/pain

Payer may or may not require op/procedure notes

NEVER used to report the elective cancellation of a procedure prior to the start of the procedure

Modifier 58 – Staged Procedure

Staged or Related procedure by the same provider during the postoperative period

This is planned or anticipated (staged)

More extensive than original procedure

Starts a new global period

Bill modifier with the subsequent performed procedure

Modifier 59 – Distinct Procedural Service

Identifies services that are not normally reported together but are appropriate under the circumstances

Documentation must support:

- Different anatomic site/organ system
- Different encounters on the same day
- Separate incision/excision
- Separate lesion/injury

When another, already established modifier better describes the circumstances, utilize it rather than 59

This is considered the most misused modifier.
Therefore, it is the most audited

“X” Modifiers

Modifier 59 should not be used when one of the -X modifiers describes the reason for the distinct procedural service. The -X{EPSU} modifiers are more specific versions of the -59 modifier

It is never appropriate to bill both the modifier 59 and a -X modifier on the same line

“X” Modifiers

XE – Separate Encounter, A service that is distinct because it occurred during a separate encounter” This modifier should only be used to describe separate encounters on the same date of service.

XS – Separate Structure, A service that is distinct because it was performed on a separate organ/structure

XP – Separate Practitioner, A service that is distinct because it was performed by a different practitioner

XU – Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service

Modifier 76 – Repeat Procedure

Repeat Procedure by the Same Physician; use when it is necessary to report repeat procedures performed on the same day

Used on procedure codes that cannot be quantity billed

Report each service on a separate line, using a quantity of one and append 76 to the subsequent procedures

The same physician must performs the services

* Medicare considers two physicians, in the same group with the same specialty performing services on the same day as the same physician

Modifier 78 – Unplanned Return to OR

Unplanned Return to the Operating/Procedure Room by the Same Physician for Related Procedure During Post-Op Period

Unplanned

Related procedure, not repeat

CMS states this modifier is to be used for treatment of complications from the previous surgery/procedure

Does not start a new global period

Modifier 78 _ Unplanned Return to OR

Usually used when complications that arise in global post-op period require a return trip to the OR

Possible reasons for return trip to OR:

- Wound dehiscence
- Wound infection
- Hardware complication
- Retrieval of surgical items left behind

Modifier 58 or 78??

Both are used when the “Same Physician” performs the 2nd procedure during the post-op period

Both can be used when the 2nd procedure takes place in operating room

Both can be used when the 2nd procedure is “related” to the first

Modifier 58 or 78??

BOTTOM LINE – Find the meaning of “related”

58 used when 2nd procedure “related” to 1st by being an additional stage of care or more extensive treatment for the underlying condition

78 used when 2nd procedure “related” by being “directly associated with the performance of the initial operation” usually due to an unanticipated clinical condition or complication

Modifier 79 – Unrelated Procedure or Service

Unrelated procedure or service by the same physician during the post-operative period.

Starts a new global period

Example:

Patient presents with two fractured legs, one receiving open treatment on Monday, the second on Friday.

Modifier 26 – Professional Component

Certain procedures and services have both a professional and a technical component

Represents only the physician portion of a service

Example: Reading/reporting by provider

TC Modifier – Technical Component

Certain procedures and services have both a professional and a technical component.

TC – Represents the Technical Component. To be used only when only the technical component is being billed

Represents only the institutional charges when there is an expense to facility

Modifier 26 & TC

Radiology is the perfect example to explain the correct use of modifier 26 & TC;

A provider has an office that he purchased an xray machine. He employs a tech to perform the testing, but then he sends the images to a radiologist to read and report on.

In this scenario:

The providers office bills for the radiology service with a TC modifier

The radiologist reading and reporting on the service will bill for the same service with a 26 modifier.

References

Current Procedural Terminology (CPT) 2017 - Professional Edition

Coding with Modifiers: CPT, Medicare, and the Real World” AAPC Webinar

“Modifier 25 In Depth Analysis & Best Practice” AAPC Webinar