



Society for  
Maternal – Fetal  
Medicine

# Modifiers

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# The Purpose of Modifiers



The purpose of modifiers is...

- A. To obtain additional payment for a service
- B. To make a service that is not payable to be payable in the present circumstance
- C. To provide job security to coders
- D. To communicate that an unusual circumstance of some sort has occurred

# Who is responsible for correct billing/coding (and modifiers?)



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- A. The biller/coder
- B. The doctor
- C. Both
- D. Neither





# WHY USE MODIFIERS?



- They give the payer additional information
- They may appropriately ↑ or ↓ payment
- Identify professional vs. technical component
- Identify if more than one provider involved for the same procedure or on the same day
- Only part of a service was performed
- More than one procedure done on the same day
- Helps speed payment



# DEFINITION: SAME PHYSICIAN



- Medicare (and most payers) states:  
"Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician."
- Occasionally two physicians in the same group with the same specialty (different subspecialties) see patients on the same day – they will have different taxonomy codes





**INCREASED  
PROCEDURAL  
SERVICE  
MODIFIER 22**



# Scenario 1



- A patient with a breech fetus at term, BMI 42
- C-section is done - it takes 2 hours to complete
- The C-Section is otherwise uncomplicated
  
- Should you bill with modifier -22?



## Scenario 2



- 5<sup>th</sup> repeat C-Section on a patient with Crohn's disease and multiple prior surgeries
- Significant intra-abdominal adhesions encountered
- Heavy bleeding noted and managed
  
- Should you bill with modifier -22?



# MODIFIER 22



- Used when the service provided is **significantly** greater than that usually required for that procedure
- Time alone – not enough!
- Document the increased intensity, time, technical difficulty, and severity of the patient's condition
- Drop claim to paper, if necessary
- Attach all pertinent info: operative note, progress notes, time in the OR, etc.
- Cover letter is recommended
- Increase your fee by an appropriate amount (payer dependent)





**UNRELATED E&M  
SERVICE  
BY THE SAME PHYSICIAN  
DURING A  
POSTOPERATIVE PERIOD  
MODIFIER 24**



# Scenario 1



- A patient presents with symptoms of perineal herpes 20 days after a vaginal delivery
  
- Is the visit part of global or can you bill a separate E/M service?



# MODIFIER 24



- Global postpartum care is for uncomplicated cases!!!
- Packing, wound debridement, etc. (and herpes outbreak) are not part of the routine post-operative care
- Reporting the E&M with the -24 modifier is appropriate when linked with the corresponding diagnosis (complication) code
- EXAMPLES:
  - Hematoma of cesarean or perineal wound
  - Infection of cesarean or perineal wound



# MODIFIER 24



## Appropriate Usage

- Documentation indicates the service was exclusively for treatment of the underlying condition and/or not for postop/PP care
- Append -24 to the E&M code
- When an E&M performed by the same physician during the postpartum or postop period
- 99202-99499 (CMS approved CPTs to use with -24)





# MODIFIER 24



## Inappropriate Usage

- Do not use for removal of sutures or other simple wound treatment
- Do not use outside of the post-op period of a procedure
- Do not use on the same day as a procedure





**SIGNIFICANT & SEPARATE  
E/M SERVICE  
BY THE SAME PHYSICIAN  
ON THE SAME DAY AS A  
PROCEDURE**

**MODIFIER 25**



# Scenario 1



- You see a patient for genetic consultation (30')
- She then has an amniocentesis + U/S guidance
  
- Do you bill ...
  - **Amniocentesis + guidance**
  
  - **Amniocentesis + guidance + consult**





# Scenario 1



- You should bill:

59000

76946

99242-25 or 99203-25

# MODIFIER 25



## Requirements:

- This is a payer specific requirement, although almost everyone requires it
- Can provide patient convenience by avoiding another visit on another day
- The E&M service must be provided on the same day as a procedure
- -25 should be attached to the E&M code





# PROFESSIONAL COMPONENT

## MODIFIER 26





# Scenario 1



- As a private practitioner, you read the images from a **limited U/S** study performed in the hospital, using hospital equipment, space, and sonographer
- You generate a signed report and send it to the requesting physician
- What do you bill?
  - 76815-26



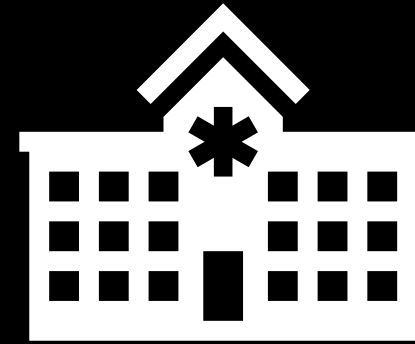


# MODIFIER 26



- Certain procedures contain a combination of physician and technical components
- -26 identifies when the physician component (interpretation) is reported separately
- There must be a separate, distinct, identifiable, written and signed document
- The split is ~ 40% professional, 60% technical

# MODIFIER 26



- Almost always used in the hospital setting
- Why?
- Would you ever bill the technical component separately?
  - Maybe—if you provide the technical service, but don't provide the professional component (e.g. Pediatric Cardiologist in your office)



**DISTINCT  
PROCEDURAL  
SERVICE**

**MODIFIER 59**



# MODIFIER 59



- **CMS: modifier of last resort**
- **Overrides NCCI edits**
  - **status indicator 1 = code pairs not normally payable on same day of service**
  - **-59 overrides that limitation**





# Scenario 1



- Patient seen for Doppler echocardiography & follow-up ultrasound
- Report 76825, 76815-59



## Scenario 2



- The patient is seen for a follow up growth scan (she is carrying twins).
  
- Report:
  - 76816
  - 76816-59



# MODIFIER 59



- A widely used modifier
- The physician indicates that a procedure or service was distinct and independent from other services performed the same day
- Identifies procedures/services not normally reported together, but appropriately billable under the circumstances
- There should be NO reduction in reimbursement
- Not for E&M



# MODIFIER 59 – X{EPSU} subset



- **XE Separate Encounter:** A service that is distinct because it occurred during a separate encounter
  - Fetal growth done at 9AM – 76816
  - Presents with bleeding in the PM – 76815-XE
- **XP Separate Practitioner:** A service that is distinct because it was performed by a different physician
  - BPP (without NST) interpreted by provider A
  - NST read by provider B (same vs. different group)
  - Avoids bundling

# MODIFIER 59 – X{EPSU}



- **XS Separate Structure:** A service that is distinct because it was performed on a separate organ/structure
  - Transvaginal CVS done on placenta A
  - Transabdominal CVS done on placenta B
- **XU Unusual Non-Overlapping Service:** A service that is distinct because it does not overlap usual components of the main service
  - Maturity amniocentesis is done – fetal lungs are mature
  - An external version is then performed



# **MULTIPLE PROCEDURES**

**performed on the same  
day/session by the same  
physician**

## **MODIFIER 51**



# MODIFIER 51



- Itemize each procedure with the highest RVU first, then in descending value, attaching the modifier to each subsequent procedure
- Many payers will reduce reimbursement:
  - Secondary procedure (50%)
  - Tertiary procedure (25-50%)
- Do NOT use with Medicare as its processing system will automatically append it to the correct procedure code
- Do not use with designated add-on codes
  - e.g. tubal ligation at time of C-Section CPT 58611

# MODIFIERS 51 & 59



-51	-59
Same procedure performed multiple times at same site	Separate incision, excision or body part
Same procedure performed multiple times at different sites	Different procedures at different anatomy sites
Different procedures performed during the same operative session	Procedures done on different patient encounters on the same day





# MODIFIERS 51 & 59 in TWINS

## ACOG



Vaginal	Baby A	59400
	Baby B	59409 -59
VBAC	Baby A	59610
	Baby B	59612 -59
C-Section	Baby A & B	59510 ( $\pm$ 22)
Repeat C-Section	Baby A & B	59518 ( $\pm$ 22)
Vaginal/C-Section	Baby B	59510
	Baby A	59409 -51
VBAC/repeat C-Section	Baby B	59618
	Baby A	59612 -51



# SCENARIO (51/59)



- If both delivered vaginally:
  - 59400 is reported for the OB Care (global) and vaginal delivery of twin A
  - 59409-59 is used for the vaginal delivery of twin B
- **Can you bill 59400 (global) + 59409-51?**



**REDUCED SERVICE**

**MODIFIER 52**



# MODIFIER 52



- Nuchal translucency was attempted – unsuccessful
- Patient returns the next day – NT was successful
- Billing options:

Day 1	Day 2
<b>Nothing</b>	<b>76813</b>
<b>76813 -52</b>	<b>76813</b>
<b>76813</b>	<b>76813</b>
<b>76801 or 76815</b>	<b>76813</b>



# MODIFIER 52



## Appropriate Usage



- Per CPT manual: at physician's discretion
- When a physician eliminates or does not complete a procedure in its entirety
- Other than because of patient's well-being
- Not for time-based or E&M services

# MODIFIER 52



“There’s no code to describe what I did—but there’s one that is close!”



**PHYSICIAN ELECTS TO  
TERMINATE A SURGICAL  
OR DIAGNOSTIC  
PROCEDURE DUE TO  
PATIENT'S WELL-BEING  
MODIFIER 53**



# Scenario 1



- During an amniocentesis, after the patient was prepped and the needle enters the skin and uterine wall, the patient changes her mind about having the amniocentesis.
- Do you bill ...
  - **Nothing**
  - **59000 (no modifier)**
  - **E/M service only**
  - **59000-52**





## Scenario 2



- Patient is taken to the O.R. for cerclage
- Anesthesia is administered
- You empty the bladder, insert retractors, then the patient's medical condition deteriorates
- The procedure is discontinued

# 53- Discontinued Procedure



**“I wanted to  
do more,  
but I  
couldn’t.”**



# MODIFIER 53



## Inappropriate use

- Discontinued prior to anesthesia
- E&M service codes

## Documentation

- State that the procedure was started
- Why discontinued
- Approximate what % done



**E&M ON THE DAY  
BEFORE  
OR THE DAY OF MAJOR  
SURGERY LED TO  
DECISION TO SURGERY  
MODIFIER 57**



# Scenario



- A patient is referred to MFM for FGR at 37 wks
- Evaluation shows severe preeclampsia
- You recommend a C-Section
- You do the C-section that afternoon
- Can you bill the E&M or is it part of the admission & delivery?
  
- E/M is billed with modifier -57

# MODIFIER 57



- Not for minor procedures
- Not for pre-planned surgeries
- Typically for cases with a 90-day postop period
  
- Check with your payers to make sure they accept modifier -57
- Used with CPT codes 99202-99499





**2 SURGEONS REQUIRED  
TO PERFORM A SPECIFIC  
PROCEDURE**

**MODIFIER 62**



# Scenario



- A primigravida has a placenta accreta. She undergoes C/S followed by hysterectomy
- The OB/GYN starts the C-Section and calls the MFM for the C-hysterectomy
- The OB/GYN bills:
  - 59510 (global); 59525-62 (C-hysterectomy)
- The MFM bills:
  - 59525-62 (C-hysterectomy)







# MODIFIER 62



- Both physicians bill the same procedure code with -62
- May be denied if only one surgeon uses -62 and the other not
- Usually surgeons with different skills
- Not if one surgeon is assisting





**REPEAT PROCEDURE  
BY THE SAME  
PHYSICIAN  
ON THE SAME DAY  
MODIFIER 76**





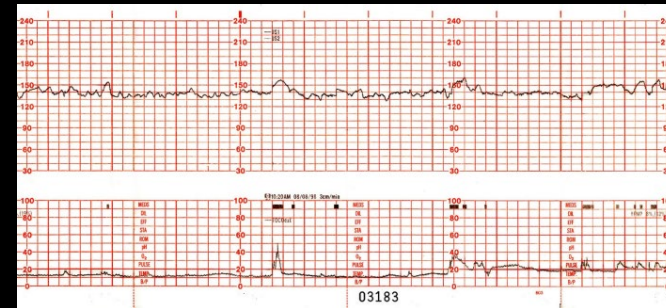
# MODIFIER 76



- Indicates that the second (same) procedure was indicated and not a duplicate bill for the original service

## EXAMPLE

- NST done in the morning and is non-reactive
- The patient is instructed to come back after lunch.
- The NST is repeated. You submit:
  - 59025 (first NST)
  - 59025-76 (second NST)





**UNPLANNED  
RETURN TO THE  
O.R. by the SAME  
PHYSICIAN**

**MODIFIER 78**



# Scenario



- After a vaginal delivery, heavy bleeding is noted
- A cervical-vaginal laceration is diagnosed
- If the laceration repair is done at the time of delivery, add modifier -59 to the repair code
- If the patient is brought to the O.R. for the procedure, use modifier -78



# OPTIONS ...



## EXAMPLE

- Vaginal delivery complicated by 4<sup>th</sup> degree tear.
- 4 options to bill for the repair:
  - Append -22 to the global or delivery only code
  - Code under surgical section depending on size/depth (12041-12042 if intermediate, 13131-13132 if complex)
  - If done at time of vag. delivery, attach -59 to the repair
  - If brought back to the OR for the repair, attach -78

# MODIFIERS -80; -81; -82; -AS

## ASSISTANT IN SURGERY





# MODIFIERS -80; -81; -82; -AS



- **-80**: the assistant is an MD or DO
  - Assistant usually performs 20-30% of surgery
  - Medicare will reimburse at ~16% of allowable
  - CPT code **must** match that reported by the surgeon
- **-81**: minimal assistance (low payer recognition)
- **-AS**: the assistant is a PA or NP (may use -81)
- **-82**: in teaching institutions when a qualified resident was unavailable or exceptionally difficult cases. **Must document!**





# TELEMHEALTH MODIFIERS



- -95 and many others
- Covered earlier during this course
- The codes there are mostly E/M services



**Let's Review...**

Only on E/M services...



24

25

57

Only on Procedures...



.....

76

52

22

26

62

79

59

78

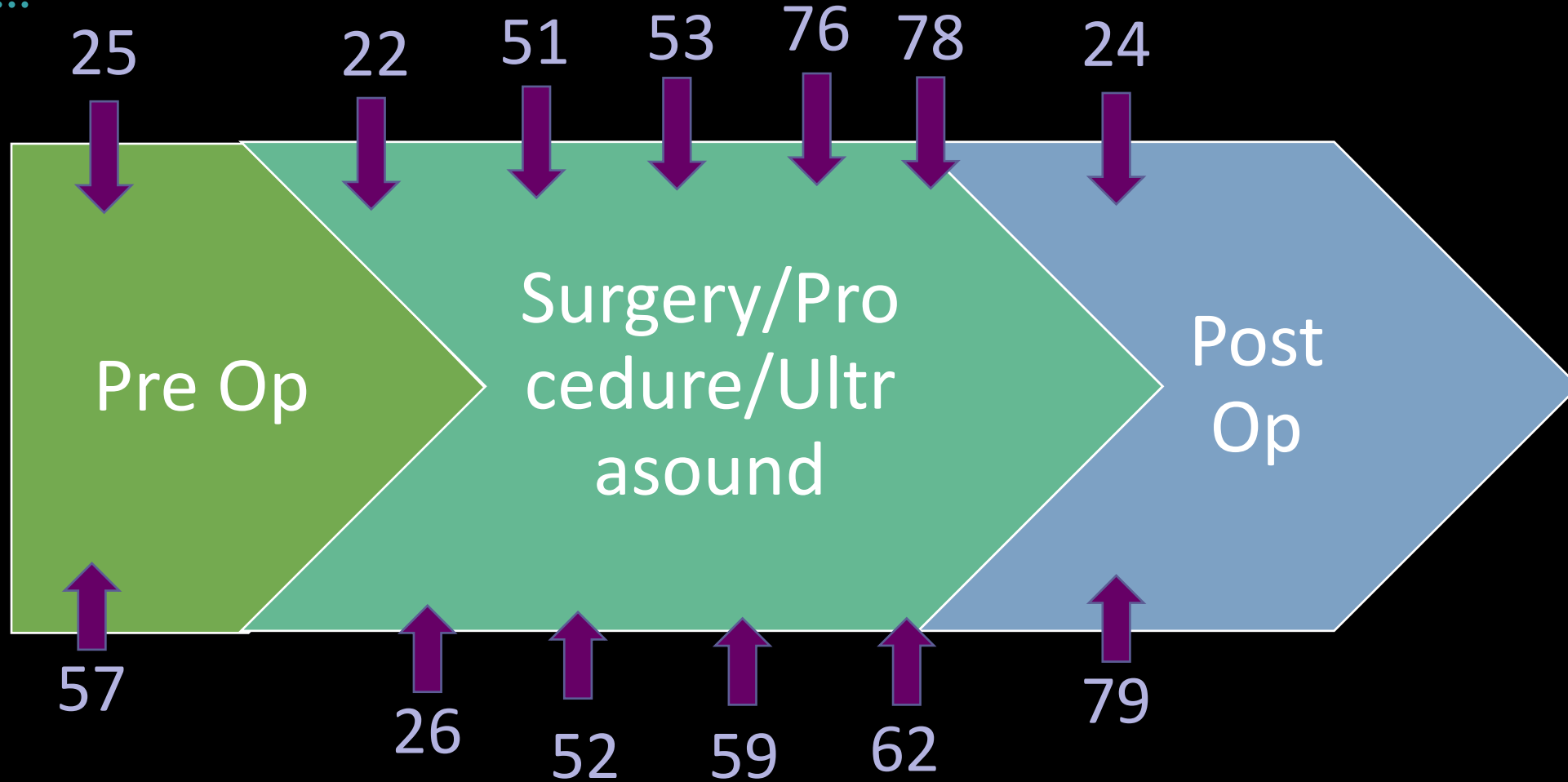
51

53

# 24 – Unrelated E/M Service 79 – Unrelated Procedure



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# QUESTIONS?

**about Modifiers?**