Ingenix Coding Lab:
Understanding Modifiers
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Introduction

Over the last 15 to 20 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 is a two-digit numeric or alphanumeric character 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.

A modifier provides the means by which a physician or facility can indicate or “flag” a service provided to the patient that has been altered by some special circumstance(s), but for which the basic code description itself has not changed.

The CPT code book, *CPT 2004*, lists the following examples of when a modifier may be appropriate (this list does not include all of the applications for modifiers, and is provided here as part of the introductory chapter to *Ingenix Coding Lab: Understanding Modifiers*):

- A service or procedure has both a professional and technical component, but both components are not applicable
- A service or procedure was performed by more than one physician and/or in more than one location
- A service or procedure has been increased or reduced
- Only part of a service was performed
- An adjunctive service was performed
- A bilateral procedure was performed
- A service or procedure was performed more than once
- Unusual events occurred during a procedure or service
- Physical status of a patient for the administration of anesthesia
Contents

Organization

_Ingenix Coding Lab: Understanding Modifiers_ is a reference for physicians and their staff as well as for billers and coders of hospital outpatient services and ASC services. It includes sections that will help physicians or facility coders validate medical record documentation to support the appropriate use of the assigned modifier(s). It also includes a final section that details compliance issues as they relate to modifier reporting.

Each section lists the modifier with its precise definition. For each modifier, guidelines are provided in the following format:

- Using the modifier correctly
- Incorrect use of the modifier
- Coding tips
- Clinical examples (when appropriate)

The clinical examples provided illustrate correct modifier usage. For additional guidance, logic trees have been developed for each modifier to help determine which modifier should be applied in various situations. The logic trees can be found in “Modifiers and Compliance” in this book.

To assist in modifier application and billing, Appendix A lists the modifiers for physician and other health care professional use, as well as the “Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use,” as described in the _CPT 2004_ code book. Considering the latter modifiers, where federal information is currently available, the CMS guidelines are provided as well.

Determining Correct Use

Determining correct modifier assignment can be very frustrating at times. If the medical record documentation does not support the use of a specific modifier the physician risks denial of the claim based on lack of medical necessity and possible fraud and/or abuse penalties if/when the medical record documentation is reviewed by federal, state, and other third-party payers.

When using this book, it is important to validate the final modifier determination against the medical record documentation. First the special circumstance must be identified in the medical record. Keep in mind, a modifier provides the means by which a physician or facility can indicate that a service provided to the patient has been altered by some special circumstance(s) but the code description itself has not changed. There should be pertinent information and adequate definition of the service or procedure performed that supports the use of the assigned modifier. If the service is not documented, or the special circumstance is not indicated, it is not considered appropriate to report the modifier.

Outdated versions of CPT may include instructions for using a five-character format for reporting modifiers. To be compliant with HIPAA guidelines, the current field length of the electronic format that holds a modifier is limited to two characters.

After verifying the medical record documentation for information that supports the use of a particular modifier, then turn to the appropriate chapter of _Ingenix Coding Lab: Understanding Modifiers_. Physicians and other health care professionals will
Chapter 1: Evaluation and Management

21 Prolonged Evaluation and Management Services

When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier 21 to the evaluation and management code number. A report may also be appropriate.

Using the Modifier Correctly

- Use only with the highest level of E/M code (i.e., 99205, 99215, 99220, 99223, 99233, 99236, 99245, 99255, 99263, 99275, 99285, 99303, 99313, 99323, 99333, 99345, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, and 99397).
- Use modifier 21 when the face-to-face or floor/unit service provided is prolonged or otherwise greater than usually required for the highest level of E/M service within a given category. Submit a report as appropriate.
- When reporting more than 30 minutes of prolonged direct (face-to-face) patient contact, it may be more appropriate to use codes 99354–99357 in lieu of modifier 21. See the key point on this page for additional information.

Incorrect Use of the Modifier

- Placing it on all levels of E/M codes
- Placing this modifier on codes outside the code range 99205–99397 or on critical care services (99291–99292) and neonatal intensive care (99295–99296), as these services are based on units of time.

Coding Tips

- Use modifier 21 to report a service greater than that described in the highest level E/M service code. However, many third-party payers consider this modifier to be informational only (i.e., no additional payment is provided). For example, the use of 21 on the E/M code has no effect on Medicare payment.
- If the provider documented all criteria for a comprehensive service (i.e., the highest level E/M code in a given category) and continued to monitor the patient beyond 30 minutes of the time stated in the code description, see the prolonged services codes (99354–99357) in the CPT code book. Prolonged services codes are adjunctive codes for which additional reimbursement is considered and are billed with any level of E/M code.

Clinical Examples

Example #1:
A 78-year-old diabetic patient is seen in the skilled nursing facility (SNF) by her internist for stage II decubitus ulcers with cellulitis. The patient's condition requires a revision of the treatment plan. The physician performs a detailed interval history, a comprehensive physical examination and medical decision making of moderate...
Using the Modifier Correctly

- Use modifier 25 when the E/M service is separate from that required for the procedure and a clearly documented, distinct and significantly identifiable service was rendered. However, although CPT does not limit this modifier to use only with a specific type of procedure or service, many third-party payers will not accept modifier 25 on an E/M service when billed with a minor procedure on the same day.
- When using 25 on an E/M service on the same day as a procedure, the E/M service must have the key elements (history, examination, and medical decision making) well-documented.
- Use modifier 25 on initial hospital visit (CPT codes 99221–99223), an initial inpatient consultation (CPT codes 99251–99255) and a hospital discharge service (CPT codes 99238 and 99239), when billed for the same date as an inpatient dialysis service.
- Use modifier 25 when preoperative critical care codes are billed within a global surgical period. Reporting these E/M services with modifier 25 indicates that they are significant and separately identifiable services.
- Use modifier 25 on an E/M service when performed at the same session as a preventive care visit when a significant, separately identifiable E/M service is performed in addition to the preventive care. The E/M service must be carried out for a nonpreventive clinical reason, and the ICD-9-CM code(s) for the E/M service should clearly indicate the nonpreventive nature of the E/M service.
- Attach modifier 25 to the E/M code representing a significant, separately identifiable service performed on the same day as routine foot care. The visit must be medically necessary.

Incorrect Use of the Modifier

- Using modifier 25 to report an E/M service that resulted in the decision to perform major surgery (see modifier 57).
- Billing an E/M service with modifier 25 when a physician performs ventilation management in addition to an E/M service.
- Using modifier 25 on an E/M service performed on a different day than the procedure. For example, a surgeon sees a patient in his office to follow-up an abnormal mammogram. After discussing the findings with the patient, he schedules and performs a breast biopsy the next day. It would be incorrect to add modifier 25 to the E/M code.
- Using modifier 25 on a surgical code (10021–69990) since this modifier is used to explain the special circumstance of providing the E/M service on the same day as a procedure.
- Using modifier 25 on the office visit E/M level of service code when on the same day a minor procedure (e.g., an endometrial biopsy) was performed, when the patient’s trip to the office was strictly for the minor procedure (e.g., biopsy).

Coding Tips

- Use modifier 25 to indicate that on the day of a procedure or other service identified by a CPT code, 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.
Chapter 2: Anesthesia

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 the modifier 23 to the anesthesia code for the basic service.

Using the Modifier Correctly

- Modifier 23 should be used on basic service procedure codes (00100–01999).
- Use this modifier when general anesthesia is administered in situations that typically would not require this level of anesthesia, or in situations in which local anesthesia might have been required, but would not be sufficient under the circumstances.
- When using modifier 23, the claim must be accompanied by both documentation and a cover letter from the physician explaining the need for general anesthesia.

Incorrect Use of the Modifier

- Appending modifier 23 to anesthesia or surgical CPT codes when billing Medicare.
- Using modifier 23 for local anesthesia.

Coding Tips

- Add modifier 23 to the procedure code for the basic service when a procedure which usually requires either no anesthesia or local anesthesia, must be done under general anesthesia because of unusual circumstances.
- CPT codes for use with modifier 23 unless limited by the payer are: 00100–01999.

Clinical Examples

Example #1
A mentally retarded, extremely anxious female patient presents to the outpatient hospital clinic for excision of a 2 cm. cystic lesion on her arm. When the physician tries to examine her, she becomes so agitated that he is unable to perform the examination. After an attempt at conscious sedation fails to calm the patient, the physician decides that an anesthesiologist must be summoned to induce general anesthesia. Since the patient has been NPO for greater than six hours, the on-call anesthesiologist is able to administer the anesthetic and the procedure is completed.

The CPT code is submitted with modifier 23 as well as HCPCS Level II modifier AA.

Example #2
An eight-year-old hyperactive child is seen in the ED with complaint of a foreign body in his left ear. It appears he pushed a round metal ball into his ear. The child is frightened and is unmanageable. The anesthesiologist is called to administer a general anesthetic so the obstructing foreign body can be extricated from the patient’s ear.

Key Point

Claims submitted to Medicare, Medicaid, and other third-party payers containing modifier 23 for unusual anesthesia that do not have attached supporting documentation that demonstrates the unusual distinction of the services will generally be processed as if the procedure codes were not appended with the modifier. Some third-party payers might suspend the claims and request additional information from the respective anesthesiologists, but this is the exception rather than the rule.

Quick Tip

The federal Medicare program bases its definition of concurrent medically directed anesthesia procedures on the maximum number of cases that an anesthesiologist is medically directing at one time, and whether or not these other procedures overlap one another. Concurrency is not dependent on each of the cases involving a Medicare patient, however. If an anesthesiologist directs three concurrent procedures, two of which involve non-Medicare patients and one that does involve a Medicare patient, this represents three concurrent medically directed cases. Base unit reductions for concurrent medically directed procedures will apply.
• Use modifier 59 only on the procedure designated as the distinct procedural service. The physician needs to document that a procedure or service was distinct or separate from other services performed on the same day.
• Ensure the medical record documentation is clear as to the separate distinct procedure before appending modifier 59 to a code. This modifier allows the code to bypass edits so appropriate documentation must be present in the record.
  Note: Medicare uses Correct Coding Initiative (CCI) screens when editing claims for possible unbundling. Under CCI screens, specific codes are identified that should not be billed together.
• Use modifier 59 only if another modifier does not describe the situation more accurately.

Incorrect Use of the Modifier
• Appending modifier 59 with E/M codes.
• Reporting modifier 59 with radiation therapy management codes.
• Using modifier 59 when another modifier is more appropriate such as 24, 25, 78, or 79.

Coding Tips
• Modifier 59 is used to indicate that a procedure or service was distinct or independent from other services performed on the same day.
• All other possible modifier choices should be reviewed before using modifier 59. It is typically the modifier of last choice.
• If there is not a more descriptive modifier available and the use of modifier 59 best explains the circumstance, then report the service with modifier 59.
• The 59 modifier is used when the physician performs an injection of a diagnostic, therapeutic or antispasmodic substance (including narcotics), CPT codes 62310–62319. These codes could be used on the day of surgery by the anesthesiologist if the injection was not performed by the anesthesiologist as the type of anesthesia provided for the surgery. If the injection was performed by the anesthesiologist following surgery (same day) for postoperative pain relief, the 59 modifier indicates this circumstance. The procedure must be well documented in the medical record and medical necessity must be clearly recorded.
• If 62311 or 62319 are performed on the same day as an anesthesia service, append modifier 59 when the procedure is performed as a separate service from the anesthesia service. If the epidural catheter is placed on a different date from the surgery, then modifier 59 would not be necessary.
• Additional spine and spinal cord injection procedures, beyond one, may be allowed when the codes are billed with modifier 59. Documentation must be made in the patient’s chart that adequately explains the patient’s history and the extenuating circumstances.
• CPT codes for use with modifier 59 are 00100–01999, 10021–69990, 70010–79999, 80048–89399, and 90281–99600, when appropriate unless limited by the payer.
• Ventilation management/pulmonary services are separately reimbursable if performed after transfer out of postanesthesia recovery to a hospital unit/ICU. The anesthesiologist would append modifier 59 to the procedure code billed (codes 94656 or 94660–94662).
Chapter 3: Surgery

22 Unusual Procedural Services
When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

Using the Modifier Correctly

- The 22 modifier is appended to the basic CPT procedure code when the service(s) provided is greater than usually required for the listed procedure. Use of modifier 22 allows the claim to undergo individual consideration.
- Modifier 22 is used to identify an increment of work that is infrequently encountered with a particular procedure and is not described by another code.
- The frequent reporting of modifier 22 has prompted many carriers to simply ignore it. When using modifier 22, the claim must be accompanied by documentation and a cover letter explaining the unusual circumstances. Documentation includes, but is not limited to, descriptive statements identifying the unusual circumstances, operative reports (state the usual time for performing the procedure and the prolonged time due to complication, if appropriate), pathology reports, progress notes, office notes, etc. Language that indicates unusual circumstances would be difficulty, increased risk, extended, hemorrhage, blood loss over 600cc, unusual findings, etc. If slight extension of the procedure was necessary (a procedure extended by 15–20 minutes) or, for example, routine lysis of adhesions was performed, these scenarios do not validate the use of the modifier 22.
- Surgical procedures that require additional physician work due to complications or medical emergencies may warrant the use of modifier 22 after the surgical procedure code.
- Modifier 22 is applied to any code of a multiple procedure claim, regardless of whether that code is the primary or secondary procedure. In these instances, the Medicare carrier first applies the multiple surgery reduction rules (e.g., 100 percent, 50 percent, 50 percent, 50 percent, 50 percent). Then, a decision is made as to whether or not payment consideration for modifier 22 (unusual circumstances) is in order. For example, if the fee schedule amounts for procedures A, B, and C are $1000, $500, and $250 respectively, and a modifier 22 is submitted with procedure B, the carrier would apply the multiple surgery payment reduction rule first (major procedure 100 percent of the Medicare fee schedule) and reduce the procedure B (second surgical procedure) fee schedule amount from $500 to $250. The carrier would then decide whether or not to pay an additional amount above the $250 based on the documentation submitted with the claim for unusual procedural services, as designated by modifier 22.

Incorrect Use of the Modifier

- Appending this modifier to a surgical code without documentation in the medical record of an unusual occurrence. Because of its overuse, many payers do not acknowledge this modifier.
- Using this modifier on a routine basis; to do so would most certainly cause scrutiny of submitted claims and may result in an audit.

Quick Tip

Hospital ASC and Outpatient Coders
Modifier 22 is not applicable in hospital ASC or hospital outpatient facilities in accordance with CPT’s modifiers approved for ambulatory surgery center (ASC) outpatient hospital use.
Using the Modifier Correctly
- The 62 modifier is added to the procedure number used by each surgeon for reporting services if the services of two physicians are required to manage a specific surgical procedure.
- Modifier 62 is used when the individual skills of physicians with different specialties are required to perform surgery on the patient during the same operative session because of the complex nature of the procedure(s) and/or the patient’s condition. In these cases, the physicians are not acting as surgeon and assistant-at-surgery, but rather as cosurgeons (e.g., two surgeons each performing a part of the procedure).
- Submit documentation with claims using modifier 62. Claims for these procedures must include an operative report that supports the need for cosurgeons. If the surgical procedures performed by each physician can be clearly identified, and each surgeon’s role is explicitly described within the operative report, then only one operative report is necessary. Otherwise, an operative report dictated by each surgeon is required. If the documentation supports the need for cosurgeons, payment for each physician will be based on the lower of the billed amount or 62.5 percent of the fee schedule amount for Medicare claims.
- Most third-party payers will deny claims by two physicians for cosurgery if the physicians are of the same specialty. On rare occasions Medicare will allow cosurgery claims for physicians with the same specialty designation. In this case, submit claims with the 62 modifier and the 22 modifier for unusual procedural services. Submit the operative report and a cover letter indicating the complex nature of the procedures.
- Although a procedure code may be on the list of procedures for which cosurgery may be covered, the 62 modifier does not apply when two surgeons, regardless of their specialties, perform distinct procedures (different procedure codes). When modifier 62 for cosurgeons is deemed appropriate, payment for an assistant surgeon is usually not allowed (the same is true for team surgeons, modifier 66). However, if it is determined that it was medically necessary to have two surgeons and an assistant surgeon, payment for an assistant surgeon may be allowed.
- Medicare has three classifications for cosurgery:
  - Surgeries that may be paid as cosurgery, but which require documentation to support the medical necessity for the two surgeons. These procedures are reported in the MPFSDB with a “1” in the cosurgery field.
  - Surgeries that may be paid as cosurgery, but do not require documentation, if the two-specialty requirement is met. These procedures are identified in the MPFSDB with a “2” in the cosurgery field.
  - Procedures which may not be billed as cosurgery. These procedures are listed in the MPFSDB with cosurgery indicators of “0” or “9.”

Incorrect Use of the Modifier
- Using modifier 62 where the physicians are of the same specialty. Third-party payers typically expect the two surgeons to have different skills. However, there may be instances of medical necessity for two physicians of the same specialty to coperform a procedure. These circumstances require documentation of medical necessity when filing the claims.
- Using modifier 62 when surgeons of different specialties are each performing a different procedure (i.e., reporting different CPT codes even if the procedures are performed through the same incision).
Chapter 4: Radiology

22 Unusual Procedural Services
When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate. Note: This modifier is not to be used to report procedure(s) complicated by adhesion formation, scarring, and/or alteration of normal landmarks due to late effects of prior surgery, irradiation, infection, very low weight (i.e., neonates and infants less than 4kg), or trauma.

Using the Modifier Correctly
- Modifier 22 is appended to the basic CPT procedure code when the service(s) provided is greater than usually required for the listed procedure. Use of modifier 22 allows the claim to undergo individual consideration.
- Modifier 22 is used to identify an increment of work that is infrequently encountered with a particular procedure and is not described by another code.
- Modifier 22 is generally not appended to a radiology code. If a rare circumstance does occur, submit detailed documentation with a cover letter from the radiologist or other provider.
- The frequent reporting of modifier 22 has prompted many carriers to simply ignore it.
- Modifier 22 is used with computerized tomography (CT) numbers when additional slices are required or a more detailed examination is necessary. However, this is subject to payer discretion. Many payers will not allow additional reimbursement for additional CT slices.

Incorrect Use of the Modifier
- Appending this modifier to a radiology code without justification in the medical record documenting an unusual occurrence. Because of its overuse, many payers do not acknowledge this modifier.
- Using this modifier on a routine basis; to do so would most certainly cause scrutiny of submitted claims and may result in an audit.
- Using modifier 22 to indicate that the radiology procedure was performed by a specialist; specialty designation does not warrant use of the 22 modifier.
- Using modifier 22 when more x-rays views are taken than actually specified by the CPT code description. This is incorrect, especially when the code descriptor reads “complete” (e.g., 70130, 70321, 73110, etc.). Complete means any number of views taken of the body site.

Coding Tips
- Using modifier 22 identifies the service as one that requires individual consideration and manual review.
- Overuse of modifier 22 could trigger a carrier audit. Carriers monitor the use of this modifier very carefully. The 22 modifier should be used only when sufficient documentation is present in the medical record.
- A Medicare claim submitted with modifier 22 is forwarded to the carrier medical review staff for review and pricing. With sufficient documentation of medical necessity, increased payment may result.

Quick Tip
Hospital ASC and Outpatient Coders
Modifier 22 is not applicable in hospital ASC or hospital outpatient facilities in accordance with CPT modifiers approved for ambulatory surgery center (ASC) outpatient hospital use.

Key Point
Claims submitted to Medicare, Medicaid, and other third-party payers containing modifier 22 for unusual procedural services that do not have attached supporting documentation that illustrates the unusual distinction of the services will generally be processed as if the procedure codes were not appended with this modifier. Some third-party payers might suspend the claims and request additional information from the provider, but this is the exception rather than the rule.

Quick Tip
Do not bombard the Medicare carrier or other third-party payer with unnecessary documentation. All attachments to the claim for justification of the unusual services should explain the unusual circumstances in a concise, clear manner. The information for the justification of unusual services should be easy to locate within the attached documentation. Highlight this information, if necessary, to facilitate the medical reviewer’s access to the pertinent supporting data.
Using the Modifier Correctly

- Modifier 52 is used for reporting services that were partially reduced or eliminated at the physician's election. Documentation should be present in the medical record explaining the circumstances surrounding the reduction in service.
- Modifier 52 is used to indicate that a procedure or service is being performed at a lesser level. A concise statement that describes how the service differs from the normal procedure must be included with the claim.
- When a limited comparative x-ray study is performed (e.g., postreduction radiographs, postintubation, postcatheter placement, etc.), the CPT code for the comprehensive x-ray should be billed with modifier 52, indicating that a reduced level of service was provided.

Incorrect Use of the Modifier

- Using Modifier 52 For Terminated Procedures. This modifier is intended for procedures which accomplished some result, but less than expected for the procedure.
- Using modifier 52 on a time-based code (i.e., critical care, psychotherapy, anesthesia), automated organ or disease panels or codes which specifically state “limited” (e.g., duplex sonography). Check with the carriers to see if they recognize modifier 52 and find out their policy for its use. In some cases, there are alternative choices for coding a lesser service, so the 52 modifier would not be appended.

Coding Tips

- Modifier 52 is used to indicate under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's discretion.
- The 52 modifier is for a reduced service and is not a modifier to be used in situations when the fee is reduced for a patient due to his or her inability to pay the full charges.
- CPT codes for use with modifier 52 are 99201–99499 (except for Medicare), 10021–69990, 70010–79999, 80048–89399, and 90281–99600 (except psychotherapy), when appropriate unless limited by the payer.

Clinical Example

An 88-year-old patient presented to the physician's office with a chief complaint of wrist pain after falling from a chair at home. X-rays (A/P and lateral views of the wrist) revealed a Colles' fracture of the right wrist. The physician performed a closed treatment with manipulation. Following the treatment, the physician ordered a postreduction x-ray.

CPT codes 25605, 73100, 73100-59-52 are used. Use of the 59 modifier in this scenario may not be required by many payers. The 52 modifier is required by Medicare when limited comparative radiographic studies are performed (e.g., postreduction, postintubation, and postcatheter placement radiographs, etc.).

53 DISCONTINUED PROCEDURE

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding the modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a
Chapter 5: Pathology and Laboratory

22 Unusual Procedural Services
When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate. Note: This modifier is not to be used to report procedure(s) complicated by adhesion formation, scarring, and/or alteration of normal landmarks due to late effects of prior surgery, irradiation, infection, very low weight (i.e., neonates and infants less than 4 kg), or trauma.

Using the Modifier Correctly
- Modifier 22 is used to the basic CPT code book procedure code when the service(s) provided is greater than usually required for the listed procedure. Use of modifier 22 on services requires individual consideration of the claim(s).
- Modifier 22 is used to identify an increment of work that is infrequently encountered with a particular procedure and is not described by another code.
- The frequent use of modifier 22 has prompted many carriers to ignore it. When using modifier 22, the claim must be accompanied by documentation and a cover letter explaining the unusual circumstances. Documentation includes, but is not limited to, descriptive statements identifying the unusual circumstances, operative reports (state the usual time for performing the procedure and the prolonged time due to any complications), pathology reports, progress notes, office notes, etc.

Incorrect Use of the Modifier
- Appending this modifier to a code without justification in the medical record of an unusual occurrence. Because of its overuse, many payers do not acknowledge this modifier.
- Using this modifier on a routine basis. To do so would most certainly flag the claim and may result in an audit.
- Using modifier 22 to indicate a procedure was performed by a specialist. Specialty designation does not warrant use of modifier 22.

Coding Tips
- Using modifier 22 identifies the service as one requiring individual consideration and manual review.
- Overuse of modifier 22 could trigger a carrier audit. Carriers monitor the use of this modifier very carefully. Make sure that modifier 22 is used only when sufficient documentation is present in the medical record.
- A Medicare claim submitted with modifier 22 is forwarded to the carrier medical review staff for review and pricing. With sufficient documentation of medical necessity increased payment may result.

Quick Tip
Hospital ASC and Outpatient Coders
Modifier 22 is not applicable in hospital ASC or hospital outpatient facilities in accordance with CPT modifiers approved for ambulatory surgery center (ASC) outpatient hospital use.

Key Point
Claims submitted to Medicare, Medicaid, and other third-party payers containing modifier 22 for unusual procedural services that do not have attached supporting documentation that demonstrates the unusual distinction of the services will generally be processed as if the procedure codes were not appended with the modifier. Some third-party payers might suspend the claims and request additional information from the respective providers, but this is the exception rather than the rule.
outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

Using the Modifier Correctly
- Modifier 52 is used for reporting services that were partially reduced or eliminated at the physician's election. Documentation should be present in the medical record explaining the reduction.
- Modifier 52 is used to indicate that a procedure is being performed at a lesser level. A concise statement that describes how the service differs from the normal procedure must be included with the claim.

Incorrect Use of the Modifier
- Using modifier 52 on a time-based code (i.e., critical care, psychotherapy, anesthesia), automated organ or disease panels or codes which specifically state “limited” (e.g., duplex sonography). Check with your carriers to see if they recognize modifier 52 and find out their policy for its use. In some cases, there are alternative choices for coding a lesser service, so the 52 modifier would not be appended.
- Using modifier 52 if the procedure was terminated either for nonmedical or medical reasons before the ambulatory surgery center (ASC) has expended substantial resources.

Coding Tips
- Use modifier 52 to indicate under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's discretion.
- Modifier 52 is for a reduced service and is not a modifier to be used just because the fee is reduced due to a patient's inability to pay.
- CPT codes for use with modifier 52 are 99201–99499 (except for Medicare), 10021–69990, 70010–79999, 80048–89399, and 90281–99600 (except psychotherapy), when appropriate unless limited by the payer.

Clinical Example
A patient presents to the lab with written orders for a glucose tolerance test (GTT), three specimens (includes glucose), CPT code 82951. Following the second specimen and before the third can be obtained the patient is paged by her infant's daycare provider, and she must leave immediately. The test is not completed.

53 DISCONTINUED PROCEDURE
Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding the modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ASC reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.
Chapter 6: Medicine

22 Unusual Services

When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate. Note: This modifier is not to be used to report procedure(s) complicated by adhesion formation, scarring, and/or alteration of normal landmarks due to late effects of prior surgery, irradiation, infection, very low weight (i.e., neonates and infants less than 4 kg), or trauma.

Using the Modifier Correctly

- Modifier 22 is appended to the basic CPT procedure code when the service(s) provided is greater than usually required for the listed procedure. Use of modifier 22 on services requires individual claim consideration.
- Modifier 22 is used to identify an increment of work that is infrequently encountered with a particular procedure and is not described by another code.
- The frequent reporting of modifier 22 has prompted many carriers to ignore it. When using modifier 22, the claim must be accompanied by documentation and a cover letter explaining the unusual circumstances. Documentation includes, but is not limited to, descriptive statements identifying the unusual circumstances, operative reports (state the usual time for performing the procedure and the prolonged time due to complication), pathology reports, progress notes, office notes, etc. Some words that indicate unusual circumstances would be difficult, increased risk, extended, etc. If a slight extension of the procedure was necessary (e.g., a procedure is extended by 15–20 minutes), this minimal prolonged time does not validate the use of modifier 22.
- Surgical or medical procedures that require additional physician “work” due to complications or medical emergencies may warrant the use of modifier 22.
- Modifier 22 is used with the following codes in the medicine section of the CPT manual, when an unusual circumstance is well-documented. The following list is not all-inclusive:
  — biofeedback procedure codes 90901 and 90911
  — hemodialysis procedure codes 90935, 90937, and 90939
  — peritoneal dialysis procedure codes 90945, 90947, and 90997
  — gastroenterology procedure codes 91000–91299
  — nasopharyngoscopy procedure codes 92502 and 92511
  — cardiovascular procedure codes 92950–92998
  — cardiac catheterization procedure codes 93501–93581
  — intracardiac electrophysiological procedure codes 93600–93660

Incorrect Use of the Modifier

- Appending this modifier to a code without justification in the medical record of an unusual occurrence. Because of its overuse, many payers do not acknowledge this modifier.
- Using this modifier on a routine basis. To do so would most certainly flag the claim and may result in an audit.

✔ Quick Tip

Hospital ASC and Outpatient Coders

Modifier 22 is not applicable in hospital ASC or hospital outpatient facilities in accordance with CPT modifiers approved for ambulatory surgery center (ASC) outpatient hospital use.

KEY POINT

Claims submitted to Medicare, Medicaid, and other third-party payers containing modifier 22 for unusual procedural services that do not have attached supporting documentation that demonstrates the unusual distinction of the services will generally be processed as if the procedure codes were not appended with the modifier. Some third-party payers might suspend the claims and request additional information from the respective providers, but this is the exception rather than the rule.
52 REDUCED SERVICES

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 the modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or canceled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

Using the Modifier Correctly

• Modifier is used for reporting services that were partially reduced or eliminated at the physician's election. Documentation should be present in the medical record explaining the reduction.
• Modifier 52 is used to indicate that a procedure or service was performed at a lesser level. A concise statement that describes how the service differs from the normal procedure must be included with the claim.
• Procedure code 93922 describes a bilateral procedure. However, sometimes the procedure cannot be performed as described in the CPT code book. For example, if a noninvasive physiologic study is performed on a patient who previously had an above the knee amputation, append the modifier 52 to code 93922 to indicate that this test was not performed in its entirety.
• Provocative testing (CPT code 91052) can be expedited during GI endoscopy. When this is performed, append modifier 52 to CPT code 91052 indicating that a reduced level of service was performed.

Incorrect Use of the Modifier

• Using modifier 52 for terminated procedures. This modifier is intended for procedures that accomplished some result, but less than expected for the procedure.
• Using modifier 52 on an E/M code for certain third-party payer claims. Many insurance companies do not recognize modifier 52 on this type of service. Check with individual payers for the accepted use of modifier 52 on an E/M code.
• Using modifier 52 on a time-based code (i.e., critical care, psychotherapy, anesthesia), automated organ or disease panels or codes that specifically states “limited” (e.g., duplex sonography). Check with carriers to see if they recognize modifier 52 with these codes and find out their policy for its use. In some cases, there are alternative choices for coding a lesser service, so modifier 52 would not be reported.

Coding Tips

• Modifier 52 is used to indicate under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's discretion.
• The use of this modifier may affect payment. For exams considered global, this modifier is informational only and does not affect payment. For other situations, such as aborted procedures, a reduction in payment may occur.
• The 52 modifier is used for a reduced service and is not a modifier to be used just because the fee is reduced to a patient due to inability to pay.

KEY POINT

The Medicare Carriers Manual (See CMS Web-based manual, pub 100) states, in part, that when procedures for which services performed are significantly less than usually required, [these services] may be billed with modifier 52 . . . [and] procedures reported with this modifier should include the following documentation:
• A concise statement about how the service or procedure differs from the usual
• The operative report

Claims reported with modifier 52 that do not include the required documentation will be processed as if there were no modifiers reported.

QUICK TIP

Hospital ASC and Outpatient Coders

Per Medicare, modifier 52, Reduced service, is used in the hospital outpatient department to identify a procedure not requiring anesthesia (meaning general, regional, or local) that was terminated after the patient was prepared for the procedure (including any sedation). Reimbursement for modifier 52 procedures is 50 percent.
Chapter 7: HCPCS
Modifiers A-V

Introduction
The HCPCS Level II codes are alphanumeric codes developed by CMS 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 manual.

Similar to the CPT coding system, HCPCS Level II codes also contain modifiers that serve to further define services and items without changing the basic meaning of the CPT or HCPCS Level II code with which they are reported. The HCPCS Level II modifiers differ somewhat from their CPT counterparts, however, in that they are composed of either alpha characters or alphanumeric characters. HCPCS Level II modifiers range from AA to VP, and include such diverse modifiers as E1 upper left eyelid, GJ opt out physician or practitioner for emergency or urgent service, and Q6 service furnished by a locum tenens physician.

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 the RT and LT modifiers, 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 in cases when the presence of a modifier causes suspension of the claim for manual review and pricing.

Ambulance Modifiers
For ambulance services modifiers, there are single alpha characters with distinct definitions that are paired together 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 reporting ambulance services, the name of the hospital or facility should be included on the claim(s). 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/free standing facility (i.e., dialysis center, radiation therapy center) other than “P” or “H”

E Residential or domiciliary/custodial facility (i.e., nonskilled facility)

G Hospital-based dialysis facility (hospital or hospital-associated)
• This modifier indicates that side of the body on which a procedure is performed. It does not indicate a bilateral procedure. Lesion removal on the right arm and left arms should be coded with modifiers RT and LT.

• Lacrimal punctum plugs are used to close the puncta located at the inner corners of the eyes. Procedure code 68761 identifies the closure of a single punctum. In situations where two puncta are treated in the same eye (RT or LT, whichever applies), the physician should then bill 68761 (RT or LT) on the first line and 68761 (RT or LT) with modifier 76 on the next line.

• Modifiers LT and RT have no effect on payment; however, failure to use when appropriate could result in delay or denial (or partial denial) of the claim.

MS Six-month maintenance and servicing fee for reasonable and necessary parts and labor, which are not covered under any manufacturer or supplier warranty

NR New when rented (DME)
• Use this modifier when the DME, which was new at the time of its rental, is subsequently purchased.

NU New equipment

PL Progressive additional lenses

Q2 CMS/ORD demonstration project procedure/service

Q3 Live kidney donor: surgery and related services
• Use the Q3 modifier to identify postoperative live kidney donor services which are reimbursed at 100 percent of the Medicare fee schedule amount.

Q4 Service for ordering/referring physician qualifies as a service exemption
• Use this modifier when the ordering or referring provider has a financial relationship with the entity performing the service, and for which the service qualifies as one of the service-related exemptions.

Q5 Service performed by a substitute physician under a reciprocal billing arrangement
• Modifier Q5 is to be applied to the end of a procedure code to indicate that the service was provided by a substitute physician. The regular physician should keep a record on file of each service provided by the substitute physician, associated with the substitute physician’s UPIN and make this record available to Medicare upon request.

• This modifier has no effect on payment.

Q6 Service furnished by a locum tenens physician
• A locum tenens physician generally has no practice of his or her own; they usually move from area to area as needed. The patient’s regular physician may submit a claim and receive Medicare Part B payment for a covered and medically necessary visit of a locum tenens physician who is not an employee of the regular physician and whose services for patients of the regular physician are not restricted to the regular physician’s office. The locum tenens physician should not provide the visit services to Medicare patients for a continuous period of longer than 60 days.

• This modifier has no effect on payment.

QUICK TIP

CMS states fraud occurs when a person knowingly and willfully deceives the Medicare program or misrepresents information to obtain the benefit of monetary value, resulting in unauthorized Medicare payment to themselves or to another party. The violator may be a participating or non-participating provider, a supplier of medical equipment, a Medicare beneficiary, or even an individual or business entity unrelated to a beneficiary. Defrauding the Medicare program of federal monies includes, but is not limited to, the following practices:

• Billing for services or supplies that were not provided (this includes billing the Medicare program for no show patients)

• Altering claim forms to obtain higher payment amounts

• Deliberately submitting claims for duplicate payment

• Soliciting, offering, or receiving a kickback, bribe, or rebate (common examples of this practices are: —paying an individual or business entity for the referral of a patient —routinely waiving a beneficiary’s deductible and/or coinsurance

• Providing falsified certification of medical necessity (CMN) forms for patients not professionally known by the physician or supplier, or a supplier completing a CMN for the physician (ordering medical equipment and/or supplies not originating from the physician’s orders)

• Falsely representing the nature, level, or number of services rendered or the identity of the beneficiary, dates of service, etc. (this includes billing a telephone call as if it were an actual patient visit)

• Collusion between a provider and a beneficiary or supplier resulting in higher costs or unnecessary charges to the Medicare program

• Using another person’s Medicare card to authorize services for a different beneficiary or non-Medicare patient

• Altering claims history records to generate fraudulent payment

• Repeatedly violating the assignment agreement and/or limiting charge amounts

• Falsely representing provider ownership in a clinical laboratory

• Unauthorized use of the Medicare program’s name or logo (a person may use neither the Medicare program’s name nor logo, and cannot use the Social Security emblem in advertising for items or services as Medicare approved
Chapter 8: ASC and Hospital Outpatient Modifiers

Ambulatory Payment Classifications
Following the implementation of Medicare’s outpatient prospective payment system (OPPS), effective August 1, 2000, hospital outpatient services and provider-based clinics are reimbursed under the 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 CMS. The APC reimbursement system for surgical procedures and other services; however, is not the same as the APG system (still in use by numerous 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 to 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 ambulatory surgery center (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 APCs system of reimbursement, the accurate coding and reporting of services has never been more critical. A few simple facts about APCs include the following:

- APCs are groups of services with homogenous or nearly-similar clinical characteristics as well as costs.
- At this time, APCs only affect hospital OP department/clinic and hospital ASC payment for Medicare patients.
- Physician payments are not affected.
- The APC payment system is correlated to the 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 to be a crucial component to the appropriate and optimal reimbursement of services by Medicare under APCs. Modifiers are addressed in the MIM, transmittal 1729, and the Medicare Hospital Manual (CMS Pub. 10), transmittal 726 (See CMS Web-based manual, pub 100-4, chapter 4). The modifier should be appended to the CPT/HCPCS Level-II procedure code. Each line item can hold two modifiers.

Key Point
Not all third-party payers will be using the new APC system of reimbursement for ASC and hospital outpatient facility services. There are several major third-party payers currently using (and seemingly satisfied with) the ambulatory patient groups (APGs) system of reimbursement for facility services.
Chapter 8: ASC and Hospital Outpatient Modifiers

Coding Tips

- As of July 1, 1998, per hospital transmittal number 726, and subsequent related transmittals CMS requires CPT and HCPCS Level II modifiers to be reported for accuracy in reimbursement, coding consistency, editing and capture of payment data.
- The appropriate modifier is appended to the CPT procedure code to communicate that the code has been altered as indicated.
- To report terminated surgical procedures, whether before or after administration of anesthesia, see modifiers 73 and 74.

25 Significant Separately Identifiable E/M Service by the Same Physician on the Same Day of the Procedure or Other Service

The physician may need 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. 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 the 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 surgery. See modifier 57.

Coding Tips

- This modifier should be used when the E/M service is separate and distinct from any procedure or other service provided. A clearly documented E/M service that is significant and separately identifiable must be in evidence.
Chapter 9: Modifiers and Compliance

**Introduction**

Almost every segment of the health care industry has been affected by the federal government’s antifraud and abuse campaigns over the last few years. Investigations of hospital billing practices, especially teaching hospitals, flooded the news media with reports of indictments, sanctions and out-of-court settlements for millions of dollars. With trepidation seeping into all areas of health care, more of the federal government’s charges of fraud and abuse committed by clinical laboratories were heard nationwide, with tens of millions of dollars being paid back to the government. Home health agencies (HHAs), skilled nursing facilities, and durable medical equipment (DME) companies were then targeted. Finally, physician practices and ambulatory surgery centers (ASCs), in state after state, have been undergoing investigations by the FBI, the Office of the Inspector General (OIG), and by CMS officials. In June 2000, the OIG released a draft version of a physician compliance guidance document targeted to solo practitioners and small physician groups. The Federal Register of October 5, 2000, disclosed the final version of this compliance guidance. Given the fact that the federal government claims it has recouped inappropriate payments and overpayments and has collected fines totaling, up to this point, to several billion dollars, there are no signs that these fraud and abuse activities will wane.

This chapter of Ingenix Coding Lab: Understanding Modifiers explains the term “compliance” and provides an overview of the federal government’s current efforts to eradicate fraud, waste, and abuse in health care programs. This chapter also provides the reader with logic trees for each modifier. The logic trees should be used by physicians and facilities as self-auditing tools to help ensure correct modifier usage.

**What Is Compliance?**

Compliance is a broad term applied in recent years to certain aspects of the administrative side of health care. Compliance specifically encompasses the appropriate coding, billing (reporting), and documentation of medical services. In particular, being in compliance suggests the correct reporting of health care services to federal programs such as Medicare or the Children’s Health Insurance Program (CHIP). This also applies to other federally funded programs, wholly or in part, such as state Medicaid or medical assistance programs. Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, even private payers have been empowered by this federal legislation to investigate, prosecute, and prevent health care fraud and abuse.

Most third-party payers, managed care organizations, preferred provider organizations, and the like have coding and billing guidelines that must be followed. Noncompliance or false reporting of services (fraud) can lead to expulsion from the...
The Medical Integrity Program (MIP) and Payment Safeguards: This system of payment safeguards serves to identify and investigate suspicious claims throughout the Medicare program, and ensures that Medicare does not pay claims that other insurers should pay as the primary insurer. MIP also ensures that Medicare only pays for covered services that are reasonable and medically necessary. These safeguards attempt to identify improper claims before they are paid and prevent the need for Medicare to pay and chase.

Improving health care industry compliance: The OIG has issued compliance program guidance for clinical laboratories, hospitals, HHAs, third-party billing companies, and compliance guidance for the DMEPOS industry (including providers of DMEPOS and suppliers/vendors of DMEPOS). There is also a physician office compliance guidance document in the works.

Substantive claims testing: CMS is now working to develop a substantive testing process to help determine whether claims are paid properly, and also whether services are actually rendered and medically necessary.

Education efforts: CMS expects Medicare contractors to undertake educational efforts directed at the provider billing community about Medicare payment rules and fraudulent activity. This education will cover current payment policy, documentation requirements, and coding changes through quarterly bulletins, fraud alerts, and local seminars.

Budget year 2000 antifraud and abuse legislative package: President Clinton’s FY 2000 budget proposal included further antifraud and antiabuse measures such as:

- Eliminating current requirements in federal law that require Medicare to make excessive payments for certain drugs; preventing abuse of Medicare’s partial hospitalization benefit
- Ensuring that Medicare does not pay for claims liable to private insurers
- Expanding CMS contracting authority to purchase high-quality and cost-effective health care
- Expanding CMS’s authority to terminate contractors who do not perform effectively.

Administration on Aging (AoA) fraud buster projects: The AoA is awarding $2 million in grants to 12 states to recruit and train thousands of retired professionals to serve as health care fraud busters who will work with older persons in their communities to review benefit statements and report potential cases of Medicare fraud, abuse, and program waste.

These programs, both singly and in combination, place a great deal of pressure on providers, coders, and billers to remain compliant with federal and state program directives and regulations. Consistent efforts in the areas of education; monitoring of documentation, coding, and billing practices; corrective action for uncovered errors or mistakes communicated by the Medicare and Medicaid programs; and prompt remittance of program overpayments have become absolutes in the physician and nonphysician practitioner billing realms. The health care industry buzz word compliance shows no signs of fading out.

QUICK TIP

In this era of increased federal investigations into physician and facility billing practices, it is prudent to conduct periodic internal audits. Doing so will help ensure billing compliance and accuracy in patient medical records. The following list details five areas of prevalent findings reported by federal or other third-party payer auditors after conducting on-site or off-site audits for HCPCS Level II coding and billing, including modifiers:

- Physician orders:
  - no physician orders on file
  - unsigned original orders
  - DMEPOS dispensed by not on orders
  - supplier forms not correlating to physician orders
  - diagnosis(es) on claim not matching orders
  - orders unclear in directions/prescription
- Diagnosis coding:
  - truncated codes
  - wrong codes
  - claim, CMN or other forms/orders not reflective of assigned diagnosis(es)
  - diagnosis does not support DMEPOS
- Service coding:
  - HCPCS code misrepresents the DMEPOS dispensed (upcoding [e.g., coding a splint as a brace or orthotic])
  - unlisted HCPCS code used when a listed code exists
  - code (service) not supported by diagnosis(es)
  - wrong HCPCS Level II code
  - HCPCS Level II modifier not applicable with HCPCS Level II code reported
  - HCPCS Level II modifier not applicable with CPT code reported
  - missing HCPCS Level II modifier(s)
- Medical records:
  - date of service not entered
  - inconsistent dates of service (forms do not match record)
  - incomplete data in record
  - diagnosis(es) not found in chart under date of service specified
  - chart not located
  - notes illegible
- Claims:
  - mislinked service and diagnosis codes
  - unlinked service and diagnosis codes
  - unlisted HCPCS codes without explanation
  - use of 99070 on DMERC claims
  - claims filed to wrong entity
  - UPIN not noted for referring physician
  - wrong HIC number for patient
Chapter 10: Modifier Descriptors

21 **Prolonged evaluation and management services:** When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier 21 to the evaluation and management code number. A report may also be appropriate.

22 **Unusual procedural services:** When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

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 the modifier 23 to the procedure code of the basic service.

24 **Unrelated evaluation and management service by the same physician during a postoperative period:** The physician 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 the modifier 24 to the appropriate level of E/M service.

25 **Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service:** The physician may need 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. 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 the 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 surgery. See modifier 57.

26 **Professional component:** Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier 26 to the usual procedure number.
Two surgeons: When two 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. Note: If a cosurgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

Procedure performed on infants less than 4 kg: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance may be reported by adding the modifier 63 to the procedure number. Note: Unless otherwise designated, this modifier may be appended only to the procedures/services listed in the 2000–69999 code services. Modifier 63 should not be appended to any CPT codes listed in the evaluation and management services, anesthesia, radiology, pathology/laboratory, or medicine sections.

Surgical team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the surgical team concept. Such circumstances may be identified by each participating physician with the addition of the modifier 66 to the basic procedure number used for reporting services.

Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia: Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient’s surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but canceled can be reported by its usual procedure number and the addition of the modifier 73 or by use of the separate five-digit modifier code 09973. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia: Due to extenuating circumstances or those due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made,