



Working with Modifiers

This provider workshop will provide you with an overview of the most commonly used modifiers and how best to use them when billing Regence.

Before beginning, please click on the “Notes” tab in the left-hand navigation to find additional information.

[Print a copy of this workshop.](#)

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Objectives

At the completion of this provider workshop, you should be able to understand:

- Definitions and application of common modifiers
- Use of National Correct Coding Initiative (NCCI) and Regence Correct Code Editor (CCE)
- How using modifiers could affect reimbursement
- How to find additional modifier resources
- Where to find additional information

Overview

- Modifiers are two-position alpha or numeric codes (e.g., 25, GH, Q6, etc.) which can be appended to a Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code.
- Regence recognizes all Health Insurance Portability and Accountability Act (HIPAA) compliant modifiers. Modifiers can be found in CPT or HCPCS manuals.
- Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote consistent and correct coding. View the [National Correct Coding Initiative and Regence Correct Code Editor Reimbursement Policy](#)

NCCI Modifier Indicators

CMS NCCI Modifier Indicator value of:

- “1” indicates that if a NCCI-associated modifier is used appropriately, separate payment for the services billed may be considered payable.
- “0” indicates that separate payment for services is not allowed

View the [Regence NCCI bypass modifier exceptions](#)

NCCI and Regence Correct Code Editor (CCE)

- CMS NCCI and Regence CCE code pairs define when two codes may not be reported together except under special circumstances. When these special circumstances are met, the proper modifier should be appended to the appropriate code to describe the circumstance.
- Regence follows the CMS modifier indicator rules for determining whether a special circumstance could be indicated by a modifier.
- Only use modifiers when appropriate. Modifier use should relate to separate patient encounters, separate anatomic sites or separate specimens.

Two categories of modifiers

Modifiers generally fall into one of two categories:

- **Informational modifiers**

Provide additional information about the service rendered

- **Functional modifiers**

Provide additional information that impacts the amount of reimbursement either directly or through the use of NCCI or CCE edits

Submitting a functional modifier that is not compatible with the base CPT or HCPCS code will delay processing of your claim.

Functional modifiers

- Some functional modifiers are valid for only certain CPT/HCPCS codes. Regence generally follows CMS guidelines in this area.
- CMS assigns Procedure Indicators to CPT/HCPCS codes, indicating whether the code is eligible for a modifier and what impact the modifier has on reimbursement.
- [Regence Reimbursement Policies](#) utilize these indicators to determine how the use of modifiers will impact reimbursement.

View the [Regence Functional Modifier List](#)

Modifier use determination example

- To determine if **CPT 21011** *Excision, tumor, soft tissue of face or scalp, subcutaneous* is eligible for an assistant surgeon, review our [Modifiers -80, -81, -82, -AS; Assistant at Surgery Reimbursement Policy](#)
 - The policy indicates that “Regence will reimburse for assistant at surgery when the procedure code has been assigned a CMS Assistant at Surgery Indicator 2”
- To determine whether the code has a valid indicator assigned, refer to the [CMS Physician Fee Schedule \(PFS\) Relative Value Files](#)

Example continued

- In the [CMS PFS Relative Value Files](#):
 1. Select the current year from the Calendar Year list.
 2. Click on the document link in the Downloads section of the Details page.
 3. Read and accept the *End User Point and Click Agreement*.
 4. Open the file titled PPRRVU with the most current date. The file is available in an Excel or text file.
 - A list of various indicators and calculators is populated across the top of the page
 - A list of CPT and HCPCS codes is populated down the left margin
 5. Scroll across the top of the page until you find the title of the modifier you want to use (column AA for assistant at surgery), then scroll down to where that column intersects with the base procedure code.
- According to this table, **CPT 21011** has an indicator of 2 for assistant at surgery; meaning that Regence will reimburse for an assistant surgeon.

Multiple modifier use

- Professional claims (*CMS-1500*) and facility claims (*UB-04*) can include up to four modifiers per CPT/HCPCS code depending upon the circumstance
- When more than one modifier is used, placement of the modifiers is critical for correct reimbursement
 - Any functional modifier that affects pricing should be placed in the primary position

Modifier -22 Increased Procedural Services

Modifier -22 is used to indicate that the work required to provide a service was substantially greater than typically required.

- This modifier should only be appended to codes as follows:
 - Codes with global days of 0, 10 or 90 in the [CMS PFS Relative Value Files](#)
 - Codes for which Regence has established 0, 10, or 90 days in the Coding Toolkit under the [Global Periods](#) section
- This modifier should not be appended to an Evaluation & Management (E&M) code
- Do not use **Modifier -22** for the sole purpose of reporting complications due to a surgeon's choice of approach or to describe a reoperation

View our [Modifier -22 Reimbursement Policy](#)

Modifier -25 Significant and Separately Identifiable Evaluation and Management Service...

Significant and Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

- **Modifier -25** is used to describe a **separate, distinctly identifiable** E&M service above and beyond other services provided during the same visit or beyond the usual preoperative and postoperative care associated with the procedure performed
- Always attach the modifier to the E&M code
- Do not use **Modifier -25** to report an E&M service resulting in a decision to perform surgery. See [Modifier -57](#)

View our [Modifier -25 Reimbursement Policy](#)

Modifier -26 Professional Component

- Certain procedures or services are a combination of a professional (provider) component and a technical component
 - The professional component represents the provider work, associated overhead and professional liability insurance cost
- Use **Modifier -26** when the physician component is reported separately
- Correct coding guidelines require that **Modifier -26** be used when the professional component of a global service is the only service provided (i.e., supervision and/or interpretation codes)

View our [Modifier -26 Reimbursement Policy](#)

Determine if a CPT/HCPCS code is eligible for a modifier by using the [CMS PFS Relative Value Files](#)

Modifier -TC Technical Component

- **Modifier -TC** is used to represent the technical component of a service or procedure and includes institutional/facility charges and the cost of equipment and supplies to perform that service or procedure
- Correct coding guidelines require that **Modifier -TC** be used when the service provided represents only the equipment or facility component of a global service and not the professional component of the same service

View our [Modifier -TC Reimbursement Policy](#)

Determine if a CPT/HCPCS code is eligible for a modifier by using the [CMS PFS Relative Value Files](#)

Modifier -50 Bilateral Procedure

Use **Modifier -50** to identify bilateral procedures that are performed at the same operative session.

- Do not use **Modifiers LT** and **RT** with **Modifier -50**
- **Exception: Free Standing Ambulatory Surgical Center (ASC) or Outpatient Hospital ASC**

If a bilateral procedure is eligible for bilateral reimbursement, report the procedure code on two lines

- The first line contains the procedure code with no modifier
- The second line contains the procedure code with **Modifier -50**
- The above exception does not apply to BlueCard[®], Innova[®], Engage[®], ActivateSM, HSA Healthplan 2.0SM, Regence EvolveSM Individual and family products and Federal Employee Program

View our [Modifier -50 Reimbursement Policy](#)

Determine if a CPT/HCPCS code is eligible for a modifier by using the [CMS PFS Relative Value Files](#)

Modifier -51 Multiple Procedures

- Use **Modifier 51** when multiple procedures are performed on the same day or at the same session by the same provider
- Append both **Modifiers -50** and **-51** if a procedure is bilateral and performed at the same time as one or more other procedures

View our [Modifier -51 Reimbursement Policy](#)

Determine if a CPT/HCPCS code is eligible for a modifier by using the [CMS PFS Relative Value Files](#)

Modifier -53 Discontinued Procedure

- **Modifier -53** is used when a physician elects to terminate a surgical or diagnostic procedure due to extenuating circumstances
- Reimbursement may be reduced according to the services performed before the procedure was discontinued and priced to a code that reflects the service performed
- Do not use **Modifier -53** to report the elective cancellation of the procedure prior to administration of anesthesia and/or surgical preparation of the patient in the operating room suite

View our [Modifier -53 Reimbursement Policy](#)

Modifier -54 Surgical Care Only

- Use **Modifier -54** for surgical services when one physician performs a surgical procedure and another provides the preoperative and/or postoperative management
- The surgical services are identified by attaching **Modifier -54** to the surgical procedure code
- Correct coding guidelines indicate that when global surgical procedure components are furnished by different providers, each provider must separately report only the service he or she performed, using the appropriate modifier

View our [Modifier -54; Surgical Care Only; Modifier -55 Postoperative Management Only; Modifier -56 Preoperative Management Only Reimbursement Policy](#)

Determine if a CPT/HCPCS code is eligible for a modifier by using the [CMS PFS Relative Value Files](#)

Modifier -55 Postoperative Management Only

- Use **Modifier -55** when one physician performs the postoperative management and another physician performs the surgical procedure
- The postoperative component is identified by attaching **Modifier -55** to the surgical procedure code
- Correct coding guidelines indicate that when global surgical procedure components are furnished by different providers, each provider must separately report only the service he or she performed, using the appropriate modifier

View our [Modifier -54; Surgical Care Only; Modifier -55 Postoperative Management Only; Modifier -56 Preoperative Management Only Reimbursement Policy](#)

Determine if a CPT/HCPCS code is eligible for a modifier by using the [CMS PFS Relative Value Files](#)

Modifier -56 Preoperative Management Only

- Use **Modifier -56** when one physician performs the preoperative evaluation and care and another physician performs the surgical procedure
- The preoperative component is identified by attaching **Modifier -56** to the surgical procedure code
- Correct coding guidelines indicate that when global surgical procedure components are furnished by different providers, each provider reports only the service he or she performed, using the appropriate modifier

View our [Modifier -54; Surgical Care Only; Modifier -55 Postoperative Management Only; Modifier -56 Preoperative Management Only Reimbursement Policy](#)

Determine if a CPT/HCPCS code is eligible for a modifier by using the [CMS PFS Relative Value Files](#)

Modifier -57 Decision for Surgery

- Use **Modifier -57** when the initial decision to perform a major surgical procedure is made during an E&M service provided the day before or the day of a major surgery
 - Major surgery is defined as any code having a 90-day global period
 - **Modifier -57** should not be used when the E&M service is associated with a minor surgical procedure (defined as having a 0- or 10-day global period)
- **Modifier -57** should be appended to the E&M code

View our [Modifier -57 Reimbursement Policy](#)

Modifier -59 Distinct Procedural Service

According to CPT, use of **Modifier -59** is limited to the following:

- Under certain circumstances to indicate that a procedure or service was distinct or independent from other non-E&M services performed on the same day
- To identify procedures or services, other than E&M services, not normally reported together but that are appropriate under the circumstances

View our [Modifier -59 Reimbursement Policy](#)

Modifier -59 continued

CPT codes submitted with **Modifier -59** will be eligible for payment when following CPT guidelines and designating a distinct or independent procedure performed on the same day by the same physician, but only to the extent that:

- Although such procedures or services are not normally reported together, they are appropriately reported together under the particular presenting circumstances
- It would not be more appropriate to append any other CPT recognized modifier to these CPT codes

View information on [NCCI bypass modifiers](#) and the *Regence Added Code Pair Edits Do Not Bypass with Modifier -59 (PDF)* list established by Regence.

Add-on codes with Modifier -59

- Add-on codes describe services performed in addition to the primary procedure and are not valid as stand-alone codes
- Regence will deny reimbursement for an add-on procedure code as a Regence Correct Coding Edit, when its primary procedure code is denied as part of a CCE code pair or [NCCI](#)
- When correct coding indicates the use of a modifier is appropriate for the primary code, that modifier must be appended to both the primary code and the add-on code
- Identified code pair edits can be viewed in the Regence [Correct Code Editor](#)

Modifier -62 Two Surgeons / Co-Surgeons

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his or 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.

- There must be unusual circumstances supporting the need for both surgeons
- The submission of **Modifier -62** appended to a procedure code indicates that documentation is available in the patient's records for review upon request, describing the circumstances resulting in the need for co-surgeons
- Each surgeon should report the co-surgery once using the same CPT or HCPCS procedure code(s) and append **Modifier -62**

View our [Modifier -62 Reimbursement Policy](#)

Determine if a CPT/HCPCS code is eligible for a modifier by using the [CMS PFS Relative Value Files](#)

Modifier -63 Procedure Performed on Infants less than 4 kg

Modifier -63 represents procedures performed on neonates and infants up to a present body weight of 4 kilograms.

- **Modifier -63** is valid for use with the CPT code range of **20000 – 69999**
- View the Appendix F *Place of Service and Type of Service*, in the *CPT Coding Manual* for specific CPT codes that are exempt
- **Modifiers -63** and **-22** cannot be billed on the same code

View our [Modifier -63 Reimbursement Policy](#)

Modifier -66 Surgical Team

Modifier -66 describes the coordinated efforts of several surgeons, often of different specialties, performing highly complex procedures in the same surgical setting.

- Each surgeon should submit a claim for the surgery he/she performed. **Modifier -66** should be appended to each CPT/HCPCS code submitted
- Team surgeons should generally not submit the same CPT/HCPCS codes
- The team surgeons may assist each other on their respective surgeries. If that is the case, use **Modifier -80** in the first position and **Modifier -66** in the second position on the appropriate procedure code

View our [Modifier -66 Reimbursement Policy](#)

Determine if a CPT/HCPCS code is eligible for a modifier by using the [CMS PFS Relative Value Files](#)

Modifier -78 Unplanned return to the operating or procedure room...

Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period

- Use **Modifier -78** when an unplanned return to the operating or procedure room is needed during the postoperative global period
- **Modifier -78** must be appended to the appropriate surgical code(s) to avoid denial of the service per our [global period policy guidelines](#)

View our [Modifier -78 Reimbursement Policy](#)

Modifiers -80, -81, -82 and -AS; Assistant at Surgery

- **Modifiers -80, -81 and -82** all represent assistant at surgery by another physician
- **Modifier -AS** represents a non-physician assisting at surgery
- The assistant at surgery must report the same codes as the surgeon (exception is when the surgeon bills a global code like maternity care)

For additional information on use of these codes and reimbursement levels view our [Modifier -80, -81, 82, -AS Reimbursement Policy](#)

Determine if a CPT/HCPCS code is eligible for a modifier by using the [CMS PFS Relative Value Files](#)

Modifiers -LC, -LD, -RC; Coronary Artery

- Percutaneous coronary artery interventions include stent placement, atherectomy and balloon angioplasty
- There are three coronary artery modifiers:
 - **Modifier -RC** Right coronary artery
 - **Modifier -LC** Left circumflex coronary artery
 - **Modifier -LD** Left anterior descending coronary artery
- For a given coronary artery and its branches, only one intervention, the most complex, should be reported

View our [Modifiers -LC, -LD, -RC Reimbursement Policy](#)

Modifiers -LT and -RT

Modifier -LT is used to identify procedures performed on the left side of the body and **Modifier -RT** is used to identify procedures performed on the right side of the body

Modifiers -LT and -RT are used when:

- A procedure is performed on one side rather than both sides of the body.
- The bilateral **Modifier -50** is not valid for the code; however, the procedure was performed on both sides of a paired organ. Procedure codes must be billed on two lines to ensure correct reimbursement.
- Radiology codes that are not eligible for a **Modifier -50** but which specify a specific limb, **-LT** and/or **-RT** may be used as well as the appropriate pricing modifier (**-TC** or **-26**). The pricing modifier is to be used in the primary position.

Resources

Thank you for completing this online workshop. We encourage your feedback or questions via [email](#).

Additional resources include:

- [Provider Web Site](#)
 - [Coding Toolkit](#)
 - [Modifiers](#)
 - [Reimbursement Policies](#)
 - [Provider Billing Disputes](#)
- [American Medical Association](#)
 - [CPT Coding Manual and CPT Assistant](#)
- [Centers for Medicare & Medicaid Services](#)
 - [CMS National Physician Fee Schedule](#)
 - [Medicare Claims Processing Manual \(PDF\)](#)