



P R O V I D E R B U L L E T I N

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To: All Providers**Subject: Modifier Review****Overview**

The Indiana Health Coverage Programs (IHCP) is currently reviewing claims for appropriate use of modifiers. Our initial findings show that some providers are not using modifiers correctly. This affects the accuracy of claims billing and provider reimbursement. Procedure code modifiers are important identifiers for billing, payment, specific services, and special circumstances.

Modifier Definition

A modifier is a two-character code that is appended to a procedure code to provide additional information about the procedure or service performed. Some modifiers are required. IndianaAIM accepts up to four modifiers per procedure code when claims are submitted on CMS-1500 and UB-04 claim forms, through the 837P and 837I transactions, and via Web interChange. Providers should include any modifier that is applicable, based on coding criteria.

Benefits of Modifiers

Using modifiers offers the following benefits:

- Describes a specific procedure or service more accurately
- Explains the circumstances under which a procedure or service was performed
- Increases billing accuracy
- Helps prevent payment delays or denials of claims

Using Modifiers Appropriately

When trying to determine whether or not a modifier is appropriate, providers should ask the following questions:

- Will a modifier provide additional information about the services provided?
- Was the same service performed more than once on the same date?
- Will the modifier give more information about the anatomic site of the procedure?

If any of these circumstances apply, it may be appropriate to add a modifier to the procedure code. It is also important that the medical-records documentation supports the use of the modifier.

Modifier 59

Our research shows that modifier 59 is often used incorrectly. Modifier 59 indicates that a provider performed a distinct procedure or service on the same day as another procedure or service. It identifies procedures and services that are not normally reported together, but are appropriate under the circumstances. **Modifier 59 should be used only when there is no other modifier to correctly clarify the procedure or service.** A distinct procedure may represent the following:

- A different session or patient encounter
- A different procedure or surgery
- A different site or organ system
- A separate incision or excision
- A separate lesion
- A separate injury or area of injury in extensive injuries

If multiple units of the **same procedure** are performed during the same session, the provider should roll all the units to a single line, unless otherwise specified in medical policy. The following example shows the correct use of modifier 59:

- A radiologist performs multiple ultrasounds on a patient who is pregnant with multiple fetuses. Proper billing would be one unit of 76815 – *Ultrasound, pregnant uterus, real time with image documentation, limited; e.g., fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume; one or more fetuses*. A separate line is used to bill for one or more units of 76816 – *Ultrasound, pregnant uterus, real time with image documentation, follow-up; e.g., reevaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, reevaluation of organ system[s] suspected or confirmed to be abnormal on a previous scan; transabdominal approach, per fetus **along with modifier 59***. The number of units is based on the number of additional fetuses examined. Documentation is required when billing for multiple fetuses.

Using modifier 59 indicates that two separate procedures were actually performed and both codes would be paid.

The following examples show inappropriate use of modifier 59:

- A patient receives an epidurography, procedure code 72275 – *epidurography, radiological supervision and interpretation*. The same procedure code is billed twice for the same date of service – once with modifier 59 and once without modifier 59. The second claim or detail for the same procedure code will be denied.
- A patient receives a synovial biopsy, 28050 – *arthrotomy for synovial biopsy; intertarsal or tarsometatarsal joint*. Procedure code 29870 – *arthroscopy knee diagnostic with or without synovial biopsy*, which is a separate procedure, is billed on the same date of service as the synovial biopsy. The second claim or detail for 29870 59 will be denied.

Other Modifiers and Descriptions

Modifier 59 should be used *only* when there is no other modifier to better clarify the procedure or service. The following are examples of modifiers that are more appropriate than using modifier 59:

- **Modifier 50** – Bilateral procedures performed during the same operative session on both sides of the body by the same physician. The units billed would be entered as “1,” because one procedure

was performed bilaterally. For example, a physician excises tumors from both feet during the same operative session. Proper billing would be one unit of 28043 – *excision, tumor, foot, subcutaneous* – 50 to indicate excision of a tumor from each foot.

- **Modifier 51** – Multiple procedures or services are performed on the same day or during the same operative session by the same physician. The additional or secondary procedure or service is identified by adding modifier 51 to the procedure or service code. For example, if an arthrodesis of the hip follows an osteotomy of the iliac in the hip, correct coding would be one unit of 27280 – *arthrodesis, sacroiliac joint, including obtaining graft* and one unit of 27146 – *osteotomy, iliac or acetabular or innominate bone* – 51.
- **Modifier 58** – Staged or related procedure or service by the same physician during the postoperative period. The procedure or service was planned prospectively at the time of the original procedure, more extensive than the original procedure, or for therapy following a diagnostic surgical procedure. This modifier is not used to report the treatment of a problem that requires a return to the operating room. This modifier is used only during the global surgical period for the original procedure. For example, a physician performs a trial implantation of one stereotactically guided, deep-brain stimulator array (61862), which proves successful. The physician then performs a subcutaneous placement of a neurotransmitter pulse generator (61885). Code 61862 – *twist drill, burr hole, craniotomy, or craniectomy for stereotactic implantation of one neurostimulator array in subcortical site* would be billed with no modifier. Code 61885 – *insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array* would be billed with modifier 58, because the second surgery was planned before the first procedure was performed.
- **Modifier 76** – Repeat procedure or service by the **same** physician, subsequent to the original procedure or service. This modifier is used to describe the same procedure or service that is repeated, rather than the same procedure or service being performed at multiple sites. For example, a patient has a fracture set at the emergency room. The patient goes home, falls, and has to return to the emergency room to have the fracture reset. If the **same** physician resets the fracture, the physician would bill the repeat procedure with modifier 76.
- **Modifier 77** – Repeat procedure or service by a **different** physician, subsequent to the original procedure or service. This modifier is used to describe the same procedure or service that is repeated, rather than the same procedure or service being performed at multiple sites. If, in the example given for modifier 76, a **different** physician resets the fracture, that physician would bill the repeat procedure using modifier 77.
- **Modifier 91** – Repeat laboratory tests on the same day to obtain subsequent (multiple) test results. This modifier is not used when tests are rerun to confirm initial results or because of testing problems with specimens or equipment. Also, this modifier is not used for any other reason when a normal, one-time, reportable result is all that is required; or when other codes describe a series of test results. For example, a patient is treated for low potassium. A potassium test is run initially, before treatment begins. After treatment, the physician orders three more potassium tests on the same day to determine if potassium levels have normalized. The tests would be billed using modifier 91 and three units of service.

Modifiers LT and RT

The modifiers LT (left) and RT (right) apply to codes that identify procedures that can be performed on paired organs such as ears, eyes, nostrils, kidneys, lungs, and ovaries. Modifiers LT and RT should be used whenever a procedure is performed on only one side to identify which one of the paired organs was operated on. The Centers for Medicare & Medicaid Services (CMS) requires these modifiers whenever appropriate.

For example, a patient with a history of fibrocystic breast disease and a family history of breast cancer underwent a percutaneous needle-core biopsy in a hospital ambulatory surgical center (ASC). A mammogram and ultrasound indicated two suspicious masses; one in the upper-right quadrant of the left breast and one in the lower quadrant of the right breast. A needle-core biopsy, procedure code 19102 – *biopsy of breast; percutaneous, needle core, using imaging guidance* was performed bilaterally using computerized tomography (CT) guidance.

Because the same procedure was performed on both breasts, modifier 50 would be appropriate in reporting the patient encounter. CT guidance was used for imaging; procedure code 76360 – *computed tomography guidance for needle placement, radiological supervision and interpretation* would be reported, in addition to the needle-core biopsies. The radiology procedures are reported using RT and LT. Table 1 shows an example of the appropriate procedure code and modifier combinations.

Table 1 – Example of Procedure Codes with Modifiers

Detail	Procedure Code/Modifiers	Units
1	19102 50	1
2	76360 RT LT	2

LT and RT are not used to indicate bilateral procedures. Bilateral procedures are indicated by modifier 50, as shown in Table 1. In the event that a procedure or service is performed on both the left and right sides on the same date or at the same time of service, and the procedure or service is not considered bilateral by Current Procedural Terminology (CPT®)/Healthcare Common Procedure Coding System (HCPCS) code definition, then the LT and RT modifiers should be billed on the **same** detail reflecting the appropriate units.

Resources

Correct use of modifiers is essential to accurate billing and reimbursement for services provided. Listed below are some of the many resources available for obtaining additional information:

- The CMS provides carriers with guidance and instructions on the correct coding of claims and using modifiers through manuals, transmittals, and the CMS Web site. Providers can access the CMS Web site at www.cms.hhs.gov.
- The National Correct Coding Initiative (NCCI) provided updates each quarter for correct modifier usage for each CPT code.
- The CPT Assistant is another valuable resource for correct modifier usage.

The IHCP continues to perform postpayment reviews of modifier usage. Further information concerning this topic will be forthcoming.

Contact Information

If you have questions about this bulletin, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.