#### CORRECT USE OF MODIFIERS IN ASC BILLING

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Modifiers are two digit symbols added to CPT procedure codes to signify the procedure has been altered in some way. Modifiers are accepted by Medicare and most other payors, however, using modifiers correctly can be confusing, since not all payors want modifiers used the same way. Not using Modifiers according to each payor's specifications can cause unnecessary denials or cause claims to not pay properly.

Certain Modifiers are for use because the patient had to return to the OR for another procedure the same day or close to the time another procedure was performed in your facility – which is referred to as the "Global Period" or "Post-operative Period." Medicare defines the ASC facility's Global Period to be 24 hours from the time the first procedure begins – it is NOT 10 or 90 days like the physician's Global Period might be. However, some payors other than Medicare might consider the Global Period to be 48 – 72 hours for ASC facilities. Some Modifiers are for use by physician practices only, some for use on facility claims only, and some are for use by both provider types.

#### -50 Bilateral Procedures

For Bilateral procedures, use the -50 or -RT/-LT modifiers when an identical procedure is performed on both the Right and Left sides of the body. The policies payors have for the use of modifiers for reporting bilateral procedures can vary. Check with each payor for their preferred method of billing bilateral procedures. Do not mix methods or modifier types. Never use the -RT/-LT Modifiers on the same code listed on the claim as one line item. Billing with one line item can only be done using the -50 Modifier (which is not accepted by Medicare). Do not mix the -50 Modifier with -RT or -LT Modifiers. Do not use Bilateral Modifiers on those CPT codes with verbiage describing procedures as "Bilateral" or "Unilateral or Bilateral".

Since Medicare no longer allows use of the -50 Modifier for billing Bilateral procedures, the following methods for billing Bilateral procedures are allowed: Do NOT use the -50 Modifier on Medicare claims.

List the same code as two line items with no Modifiers:

64475 64475

➤ Bill the code as one line item, with no Modifier and list a "2" in the Units field on the claim form – be sure to double the fee, if this method is used:

64475 2 Units

If you experience denials using either of the above methods on your Medicare claims, try using the –RT and –LT Modifier method.

➤ Bill the same code twice with the –RT and –LT Modifiers:

64475-RT 64475-LT The other methods for billing Bilateral Procedures to payors other than Medicare include the following:

 $\triangleright$  Bill the same code twice with the -50 Modifier on the  $2^{nd}$  code:

64475 64475-50

➤ Bill the code as one line item, with the -50 Modifier – be sure to double the fee if this method is used:

64475-50

#### -51 Multiple Procedures

ASCs should not use the –51 Modifier on their claims, unless the payor requires its use. Even though Medicare EOBs have -51 Modifiers appended, DO NOT bill claims to Medicare using this modifier. When more than one procedure (excluding Evaluation & Management physician visit codes) is performed on the same day during the same encounter by the same physician, modifier –51 should be appended to the subsequent procedures on the physician's claim. The exception to this guideline is if the CPT code is an Add-on code, or if it is –51 Modifier-exempt. The -51 modifier does not have the same use as the -59 Modifier.

#### -52 Reduced Services

Use this modifier when a procedure is partially reduced or eliminated at the physician's discretion (not the same as a Terminated Procedure, where you would use the -73 or -74 Modifier). Medicare states that "the intended use of this modifier is to report the reduction of a service without disturbing identification of the basic procedure." It is used to indicate that part of the procedure was not completed or some part of a multiple-part service was not performed. Medicare and other payors might reimburse at a lower rate when this modifier is used.

# -58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

Use this modifier to indicate the performance of a procedure or service during the Global Period that was:

- 1. Staged;
- 2. More extensive than the original procedure; or
- 3. For therapy following a diagnostic surgical procedure.

An example of this would be where the surgeon performs a Breast Biopsy procedure, waits for the frozen section biopsy (which is positive), and proceeds to a Mastectomy or Lumpectomy procedure during the same case.

#### -59 Distinct Procedural Service

Use this modifier to indicate the procedure was distinct or independent from other procedures performed during the same case, to identify procedures not normally reported together (due to CCI edits or "Separate Procedure" status in the CPT book), but which are appropriate under the circumstances, or to represent a different procedure or surgery, separate compartment, different site or organ system, separate incision/excision, separate lesion or separate injury not normally encountered or performed on the same day by the same surgeon. This modifier may override edits in the payor's system, which would normally deny the code (i.e., Unbundling, etc.), but under special circumstances, the modifier can be used to make the service payable – thus, the -59 Modifier has a higher audit potential with Medicare and other payors. **Do not use a –59 modifier on the 1**st code listed on the claim form. \*\*Claims filed with this Modifier may be under close

review by Medicare. Do NOT use this Modifier unless it is absolutely necessary (the situation where CPT codes are Unbundled and will be denied without use of the -59 Modifier) – do not use the -59 Modifier like a physician would use the -51 Modifier, merely to indicate an additional procedure was performed.

# -73 Discontinued Ambulatory Surgery Center Procedure Prior to the Administration of Anesthesia

This modifier is appended to the CPT code for the intended procedure(s) to indicate that a procedure was terminated due to medical complications after the patient had been prepared for surgery and AFTER the patient has been taken to the OR or procedure room where the procedure will be performed, but *before* anesthesia was induced. The ASC must have "expended significant resources" to charge for the scheduled procedures using this modifier.

# -74 Discontinued Ambulatory Surgery Center Procedure After the Administration of Anesthesia

This modifier is appended to the CPT code for the intended procedure(s) to indicate that a procedure was terminated due to medical complications *after* anesthesia for the procedure was induced.

## **Terminated Surgical Procedures**

# Procedures which are Cancelled or Postponed

If a procedure is cancelled due to medical or non-medical reasons before the ASC has expended substantial resources, no payment is allowed by Medicare. **Do not bill.** 

#### Procedures which are Terminated Before Anesthesia has been Induced

If a procedure on a Medicare patient is terminated due to medical complications after the patient has been prepared for surgery and is taken to the procedure room or OR where the procedure was to be performed, but before anesthesia has been induced, Medicare should reimburse at 50% of the allowed amount. Append the –73 Modifier to the billed CPT code for the 1<sup>st</sup> procedure that was planned/scheduled, but was not performed.

\*\*\*The patient MUST be physically located in the OR or procedure room when the procedure is called off in order to bill Medicare. If the procedure is called off when the patient is in the Pre-Op or pre-procedure holding area, it is not billable to Medicare.

#### Procedures which are Terminated After Anesthesia has been Induced

If a procedure on a Medicare patient is terminated due to medical complications after anesthesia has been induced, Medicare should reimburse at 100% of the allowed amount. Append the –74 Modifier to the billed CPT code if the 1<sup>st</sup> procedure has been started and the patient has received anesthesia for the case.

- o When anesthesia was administered only, but **none** of the procedures which were planned were started at all, bill the code for the 1<sup>st</sup> procedure with the -74 Modifier and the rest of the planned procedures are not billable.
- o If several procedures were to be performed and some (but not all) planned procedures were completed, bill as follows:

- Bill procedure(s) which were completed at full fee without the -74 Modifier.
- 2. Bill those procedure(s) which were started but **were not** completed at full fee with the -74 Modifier.
- 3. Those procedures which were planned but were not started at all are not billable.

#### Termination of an IOL Procedure

For procedures involving an IOL insertion and the IOL was not inserted, the allowance for the unused IOL will be deducted from the ASC's payment prior to calculating the facility's payment. If you wasted the IOL and received no credit from the supplier for the IOL, write a letter to Medicare notifying them the IOL was opened, so you will be reimbursed – since the IOL was wasted. If the supplier gave you full credit, use modifier –FB on Medicare claims. If the supplier gave you a partial credit, use modifier –FC on Medicare claims.

#### Documentation

The documentation requirements for Medicare claims for discontinued procedures are quite laborious. The information can be captured on the OP Report or by completing a form with the information, or it can be recorded by a nurse. The surgeon must sign the documentation, regardless of who completes the required documentation.

#### -76 Repeat Procedure or Service by Same Physician

Use this modifier when an identical procedure is performed following the initial procedure during the Global Period.

## -77 Repeat Procedure or Service by Another Physician

Use this modifier when the same physician repeats the same procedure that had previously been performed by another physician during the Global Period, which is usually assumed to occur on the same day that the initial procedure was performed.

#### -78 Return to the OR for a Related Procedure During the Postoperative Period

This modifier is used when another procedure is performed on a patient during the Global Period, which for the ASC would usually involve Post-Operative Bleeding. Use this Modifier on the code for the subsequent procedure performed to control the hemorrhage.

## -79 Unrelated Surgery during the Postoperative Period

Use this Modifier when you have a patient with one specialty type of procedure performed one day (a Cataract Extraction) and a Hysterectomy the following day, for example. Cataract procedures performed on opposite eyes one day apart would also be billed using this modifier on the subsequent procedure billing.

-RT -LT Right Side Left Side

It is extremely important to use the –RT and –LT Anatomic Modifiers on eye procedures and for podiatric procedures. Many orthopedic procedures require the use of these modifiers, as well. Not using them when they are necessary can have a significant effect on reimbursement. If you bill a procedure that will be done bilaterally without the modifier for that side, when you

subsequently bill the procedure for the other side, it may (needlessly) be denied as a Duplicate claim, which will have to be appealed.

#### -TC Technical Component

The –TC Modifier reflects that the Technical Component only of an x-ray or fluoroscopy is being billed by the ASC. This modifier represents the taking of the x-ray and ownership of the equipment used in the scan by the facility.

# **Ophthalmology Modifiers:**

(Do not use –RT or –LT Modifiers with these modifiers)

- **-E1** Upper Left Eyelid
- -E2 Lower Left Eyelid
- -E3 Upper Right Eyelid
- -E4 Lower Right Eyelid

#### **Digit Modifiers:**

(Do not use –RT or –LT Modifiers with these modifiers). Digit Modifiers are used when procedures are performed on the Phalanx or above – not on the Metatarsal or Metacarpal areas or below – for those areas, use the –RT or –LT Anatomic Modifiers.

#### Finger Modifiers

-FA	Left hand, thumb	-F5	Right hand, thumb
-F1	Left hand, second digit	-F6	Right hand, second digit
-F2	Left hand, third digit	- <b>F7</b>	Right hand, third digit
-F3	Left hand, fourth digit	-F8	Right hand, fourth digit
-F4	Left hand, fifth digit	-F9	Right hand, fifth digit

### Toe Modifiers

-TA	Left foot, great toe	-T5	Right foot, great toe
-T1	Left foot, second digit	-T6	Right foot, second toe
-T2	Left foot, third digit	<b>-T7</b>	Right foot, third digit
-T3	Left foot, fourth digit	-T8	Right foot, fourth digit
-T4	Left foot, fifth digit	-T9	Right foot, fifth digit

It is not necessary to use -59 Modifiers with the Ophthalmology or Digit Modifiers, unless you need to report more than one procedure on the *same* Eyelid, Toe, or Finger, *when* it is separately-billable (performed in a different area, by separate incision, different joint, etc.).

# -SG Surgery Center

ASCs need to use an –SG Modifier on each CPT code billed on claims filed to Medicare for dates of service in 2007 and before (and sometimes on Medicaid claims, if required), to indicate it is a bill from a Freestanding ASC facility, since these claims are filed on CMS-1500 claim forms. Most Medicare Carriers do not require the use of this Modifier any longer. It is NOT necessary to use the –SG Modifier on codes listed on claims filed on UB-04 claim forms filed to payors other than Medicare, unless the payor requires its use. Do NOT use the –SG Modifier on Radiology or HCPCS codes billed for Implants – this can cause denials. For dates of service in 2008 forward, ASCs should not submit claims using the –SG Modifier on CPT codes, unless specifically directed by your state's Medicare Carrier to do so.

#### -GA Modifier ABN on File

It is against Medicare rules for ASCs to have patients sign Advanced Beneficiary Notices (ABN) and pay the ASC out-of-pocket for procedures not covered in an ASC by Medicare when that procedure is covered in another place of service (such as a hospital). ASCs should NOT use this Modifier on CPT codes that are covered in a different place of service, just because the code is not on the Medicare list of covered procedures for ASCs. CMS changed the rules in 2001 to not allow ASCs to have patients sign ABNs for non-covered procedures performed in the ASC setting when the procedure is not on the Medicare List of covered procedures, but it is covered in another setting. Correct use of this modifier is for procedures which are not a Medicare benefit, such as the use of Presbyopia-Correcting IOL lenses in a Cataract Extraction procedure.

#### -GY Modifier Non-Covered Procedure

When billing a CPT code to a payor you know is not covered by that payor (for example, billing 77003 Fluoroscopy to Medicare), append the –GY Modifier, which lets the payor know you that you are aware they don't cover the service and you expect a denial for that charge. This code would be billed to Medicare as 77003-GY-TC. Use this modifier when you are trying to "bill everyone the same." Of course, you don't have to bill those procedures which are not covered.

There is *verbiage change* for the –GY Modifier effective July 1, 2007. Prior to July 2007 the verbiage stated "The –GY Modifier is to be used when providers need to indicate that the item or service they are billing is statutorily non-covered or is not a Medicare benefit". As of July 1, 2007 the verbiage states "The –GY Modifier is to be used when physicians, practitioners, or suppliers what to indicate an item or service is statutorily excluded, does not meet the definition of any Medicare benefit or Non-Medicare insurers, is not a contract benefit".

#### -FB Devices/Implants replaced at no cost or w/Full Credit

In ASCs, when implants/devices are replaced at no cost or with Full Credit to the ASC, CMS will reduce payment to the ASC by the device offset amount they estimate represents the cost of the device. In accordance with policy beginning in CY 2008, CMS will reduce the amount of payment made to ASCs for certain covered surgical procedures, when the necessary device is furnished without cost to the ASC or the beneficiary or with a full credit for those costs of the device being replaced. When a procedure listed in CMS' Final Rule in *Table 58* (page 1030 CMS-1392-FC) is performed in an ASC and the case involves implantation of a no-cost or full credit device listed in *Table 59* (page 1031 CMS-1392-FC), the ASC must report Modifier –FB on the line with the covered surgical procedure, to indicate that an implantable device in Table 59 was furnished without cost. The payor will reduce the ASC's payment by the amount of payment that CMS attributed to the device when the ASC payment rate was calculated.

## -FC Devices replaced with partial credit

In ASC facilities, when implants/devices are replaced with Partial Credit to the ASC, CMS will reduce the ASC's payment for implantation procedures listed in CMS' Final Rule in Table 58 by one half of the device offset that would be applied if a replacement device were provided at no cost or with full credit. ASCs need to append Modifier –FC to the code for the procedure in which the device was inserted on claims when the device that was replaced with partial credit under warranty, recall, or field action is one of the devices in Table 59. The partial credit adjustment will be made to the national unadjusted rate, similar to what occurs when a device is replaced at full credit or with no cost. Beneficiary coinsurance should be adjusted to reflect the reduced payment amount.

In order to report that your facility has received a partial credit of 50% or more of the cost of a replacement device, ASCs have two options, which are listed in pages 1027-28 of CMS-1395-FC:

- Submit the claim to Medicare after the procedure, but prior to the supplier's acknowledgement of credit for the replacement device.
- Hold the claim for device replacement until the final determination is made by the supplier.

### **Modifier Usage**

It is extremely important to append the appropriate -RT and -LT Anatomic Modifiers to CPT codes on claims, when needed (e.g., Orthopedic, Podiatry, and Ophthalmology services). When a patient has a bilateral problem (such as Bunions on both feet or Cataracts on both eyes), the surgeries to correct the problem may be done one side at a time, with the patient returning months later for the repeat procedure on the other side. If the claim for the first surgery is submitted without the appropriate –LT or –RT Modifier, many times when the payor receives the claim for the second surgery, they will deny it as a Duplicate claim. It saves a great deal of time, energy and money to append the appropriate Modifier to the code filed the first time through, to avoid these types of unnecessary denials.

## **Multiple Modifiers**

When using more than one Modifier on a CPT code, append those modifiers which effect payment (i.e., Modifiers -GY, -59, -73, -74, -50, -52, etc.) before those modifiers which are informational only (i.e., -LT, -T3, -78, etc.). If using the –SG Modifier, it is always placed first on the CPT codes, followed by other modifiers, when it is used. If you run out of space for all necessary modifiers in the usual field on the claim form, append the first or second essential modifier, followed by the –99 modifier, then continue the other modifiers in the other information field (field 19 on a CMS-1500) on the claim form.

10/09 Compiled by Ellis Medical Consulting, Inc. Stephanie Ellis, R.N., CPC www.EllisMedical.com QUESTIONS?