Modifiers—the pairs of numbers or letters added to five-digit procedure codes—can make a big difference in whether your outpatient surgery facility gets paid correctly for its services.

Modifiers help give the payer more information about a procedure than just the CPT or HCPCS code provides.

“Modifiers are very important because some can increase or decrease reimbursement,” says Stephanie Ellis, RN, CPC, a coding expert with Ellis Medical Consulting, Inc, Brentwood, Tenn (www.ellismedical.com). If used incorrectly, modifiers can cause a surgery center not to be paid the right amount, to have a claim denied, or to be paid for something it should not have been paid for—possibly creating a fraud and abuse issue with Medicare and other payers.

Some of the same modifiers for outpatient procedures apply to services provided in hospitals or freestanding ambulatory surgery centers (ASCs). The modifiers with definitions are listed in CPT and HCPCS coding manuals published by the American Medical Association (www.ama-assn.org).

Any time a modifier is used, there must be supporting documentation in the operative report, Ellis emphasizes.

Here are some common pitfalls for using modifiers and how to avoid them.

**Avoid overuse of –59 modifier**

The –59 modifier is used to identify procedures or services not normally reported together but that are appropriate under some circumstances—for example, removing moles on a patient’s thigh and on her shoulder. This modifier is used when surgery is done during the same session but on different sites or organ systems, on a separate lesion, or for a separate injury.

“Surgery facilities often overuse this modifier when they should use another more appropriate modifier that doesn’t have such a high audit risk,” Ellis says.

The –59 modifier should not be used in place of the right and left modifiers (–LT and –RT) or finger, or toe, or eye modifiers, for example. If a bunionectomy is done on the big toe and a hammertoe procedure on the third toe, for instance, the toe modifiers would be used to indicate these procedures were done in separate areas. That is because the hammertoe code is unbundled from the bunionectomy procedure; in other words, the hammertoe procedure is not normally billable with the bunionectomy procedure when both procedures are done on the same toe, but they are billable when performed on different toes.

**Know when to use bilateral modifiers**

It’s important to know when to use the –50 modifier for bilateral procedures and when to use another instead. “Don’t use the –50 modifier with the finger, toe, or right or left modifiers—use one or the other,” Ellis notes.

Also, don’t use the –50 modifier if the code descriptor already states the procedure is “bilateral,” or “unilateral or bilateral.” An example is 22520: Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection, thoracic. This code does not need the –50 modifier because laterality is included in the description.

Payers have different requirements for billing of bilateral procedures. Ellis finds these two methods work best and are the least confusing:

- Bill the same code as two line items with no modifier on the first line and the –50 modifier on the second line.
- Use the same code on two lines with –RT on one coding line item and –LT on the second line item.

“Never bill a code as one line item with –RT and –LT on the same line-item code,” she emphasizes.
She does not recommend another seldom-used method—billing the same code as two line items with no modifier on either one, unless that method is required by the payer for billing bilateral procedures.

**Use right and left modifiers appropriately**

The –LT and –RT modifiers are used for procedures on mirrored body parts such as eyes, ears, fingers, and toes.

“The right and left modifiers stand alone,” Ellis says. “You don’t use them with the bilateral-procedure modifier, and you seldom need a –59 modifier.”

Be sure to use an –LT or –RT modifier even if the patient is having surgery on only one side of a mirrored body part, such as a single bunionectomy or cataract.

“If you don’t use the right or left modifier for a single procedure, and the patient comes back to have the second side done later, you risk having a denial for a duplicate claim,” she says.

**Use finger, toe modifiers properly**


“Use of these digit modifiers is very important to distinguish sites, especially when the codes are unbundled from each other,” Ellis says. –LT and –RT are not needed when using the finger and toe modifiers because the digit modifiers are more specific.

**Be aware of eye modifiers**

The blepharoplasty procedure was added to the Medicare grouper list in July.

“It is very important to use the eye modifiers on the blepharoplasty codes to indicate which lid the procedure was performed on,” Ellis notes. The –LT or –RT or –59 modifiers are not needed when using the eye modifiers (–E1 to –E4).

**Use multiple-procedures modifier appropriately**

The –51 modifier is not necessary for outpatient surgery facility claims unless the payer requires it, Ellis notes.

“It won’t necessarily cause your claim to be denied, but it can cause the facility claim to be paid like a physician claim, and you might not be paid appropriately.”

**Know which modifiers to use for repeat procedures**

Modifiers –58, –76, and –77, which refer to repeat procedures during the postoperative period, can cause confusion. These modifiers are intended primarily for physicians’ office practices, where patients may return for postoperative follow-up.

“If the patient comes back to your facility later for a related procedure or a repeat of a procedure that was recently performed, the ASC doesn’t need to put any specific modifier on the code because the patient is outside the ‘global period,’ which is 24 hours for an ASC,” says Ellis.

If more than one procedure is done during a single case, surgery facilities would use the –59 modifier (or one of the other modifiers signifying multiple procedures when appropriate) if the codes are unbundled from each other or where one of the codes is designated as a “separate procedure” in the coding book but is performed through a separate area, separate incision, etc.

**Document completely for terminated cases**

If a procedure was started but terminated before it was completed, surgery centers face significant documentation requirements to get paid for that case. The –73 and –74 modifiers are used for this purpose. Be sure your physicians, nurses, and office staff understand the documentation requirements for terminated cases.

Ellis cautions, “Simply putting in the op report that the procedure was terminated because the patient’s blood pressure fell is not sufficient. If you don’t have further documentation, and you are audited, you will have to scramble to amend
the op report." If auditors aren’t satisfied, Medicare can take back the reimburse-
ment for that procedure.

Here are the basic Medicare rules for terminated procedures:

• If the case is terminated after the patient comes to the facility but before the
patient is given any sedation, the case is not billable. That is true even if the
patient is gowned and on a gurney in the holding area but has not had an IV
started or has not been given preop medication.

• If the case is terminated after sedation has been given but before full anesthe-
sia is administered, the procedure is billed with the –73 modifier and paid at
50% of the usual allowable amount.

• If the case is terminated after full anesthesia is administered, the procedure is
billed using modifier –74 and paid at 100% of the usual allowable amount.

If more than three procedures were planned, but only one was completed before
the case was terminated, the facility should bill for the first procedure as usual with
no modifier and bill for the second, third, and any other procedures not completed
with –74 modifiers.

For complete documentation requirements, see Medicare’s terminated procedures
policy for your state. To assist with documentation, Ellis suggests developing a form
listing the documentation requirements for terminated procedures for circulating
nurses to complete. The form needs to be signed by the nurse who completed it and
included in the patient’s medical record with the operative report.

If a cataract surgery is terminated, and the intraocular lens (IOL) was not
opened, that information needs to be indicated in the operative report, and
Medicare will deduct approximately $150 from the cataract procedure payment,
which is the amount allowable for the lens. If the IOL was opened but not used,
that also needs to be documented; the report and invoice should be sent with the
claim to make it clear the lens was wasted.

In addition, diagnosis codes V64.1, V64.2, or V64.3 need to be used for terminated
procedures. These codes indicate the reasons why the surgery was not completed. Bill
these codes in the last position on the claim form and link them only with the codes that
have the –74 or –73 modifiers.

Know the modifier alphabet

Know when to use modifiers with letter pairs, including –GY, –TC, and –SG.
These are found in the HCPCS coding manual.

–GY modifier. This –GY modifier tells Medicare your facility is aware that a procedure
code it is billing for is not on the Medicare grouper list of procedures approved for
payment in freestanding ASCs. This modifier is used when an ASC wants to bill all
payers the same even though the procedure is not payable by Medicare in an ASC.

–TC modifier. This modifier is added to a service, such as the fluoroscopy codes
used during pain management procedures, to indicate the facility is billing for
the technical component of the service only. If there is no –TC modifier,
Medicare might assume your facility was billing for both the professional
(physician’s fee) and technical components, which wouldn’t be appropriate in
most cases.

–SG modifier. ASCs should use the –SG modifier on all surgical procedures
when billing Medicare to indicate the procedure was performed in an ASC.
Some Medicaid payers may also require it.

“This simply tells the payer it is a surgery center claim so they will not pay it
as a physician claim,” Ellis says.

The –SG modifier is always listed first, before any other modifiers. This modifier
is not needed on claims sent to payers using the UB-92 claim form unless the payer
requires it. The –SG modifier may be needed in states such as Washington that use
the HCFA-1500 form for most of their claims. Requirements vary by payer and state.

CPT codes and modifiers are copyrighted by the American Medical Association.
Test yourself on ASC modifiers

1. When a hammertoe procedure is performed on the right second toe, the most appropriate modifier would be:
   a. –T6
   b. –F6
   c. –RT

2. On claims going to Medicare, what modifier is needed on every procedure code billed to indicate the claim is for a freestanding ASC facility billing?
   a. –SG
   b. –GY
   c. No modifier needed

3. A patient is brought in for a procedure, and anesthesia is administered, but the patient develops elevated blood pressure, and the procedure is terminated before it is completed. Which modifier is most appropriate?
   a. –52
   b. –53
   c. –74
   d. None of these

4. When a bilateral procedure is performed, and the proper code is defined in the coding book as inherently unilateral, what modifier should be appended to indicate a bilateral procedure?
   a. –50 to the second line item of the same code
   b. The appropriate –RT or –LT modifier
   c. Contact the payer for specific guidelines for billing bilateral procedures

5. When a procedure designated in the coding book as a “separate procedure” is carried out independently or distinctly from other procedures performed during the same case, it must be reported with the –59 modifier to avoid denials (even if the procedure codes are not unbundled from one another).
   a. True
   b. False

6. What modifiers should be appended to the 76005 Fluoroscopy code used during a pain management procedure performed on the right side?
   a. –RT
   b. –TC
   c. –TC-RT
   d. No modifiers should be used

7. What is the correct sequencing of modifiers on a claim for a cataract extraction of the right eye being filed to Medicare when the procedure was terminated prior to completion but after administration of anesthesia?
   a. 66984–SG-74
   b. 66984–SG-74-RT
   c. 66984–74
   d. No modifiers are needed on this code.
What order do modifiers go in?

Modifiers are placed after the code in order from highest to lowest importance.

“Modifiers that affect reimbursement are always listed first. Those that are for information only are in the dependent position,” Ellis says.

An example of the correct order:

- SG: Indicates an ASC claim
- 99: Indicates multiple modifiers are being used
- GY: Is used for procedures not on Medicare’s ASC list (eg, radiology procedures such as fluoroscopy)
- 73, 74: Is used for terminated procedures
- TC: Indicates the facility is billing for the technical component only of a radiology procedure, as with fluoroscopy
- 59: Is used to avoid unbundling denials to indicate more than one procedure in different anatomic areas
- LT, RT, finger, toe, or eye modifiers

The HCFA-1500 form has places for only two modifiers by the procedure being billed. If you need more than two, the –SG modifier goes first, followed by the –99 to indicate multiple procedures. The remaining modifiers are bumped to a different field on the claim form that is provided for that purpose.