HCFA Requires Use of Modifiers for Hospital Outpatient Services

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On January 7, 1998, the Health Care Financing Administration (HCFA) released the final instructions on hospital outpatient modifiers from Medicare Hospital Manual transmittal number 726 dated January 1998. These instructions were electronically released to the Medicare fiscal intermediaries, who should notify hospitals 60-90 days prior to the effective date. If you have not received this information at your hospital, contact your local fiscal intermediary. The information contained in this article comes directly from Medicare Hospital Manual transmittal number 726. Check with your fiscal intermediary for local guidelines, which may vary from the information printed here.
Section 442.9 of the transmittal, Use of Modifiers in Reporting Hospital Outpatient Services, provides instructions for the use of HCPCS Level I (CPT) and HCPCS Level II (National) modifiers in reporting hospital outpatient services. HCFA will require specific modifiers for accuracy in reimbursement, coding consistency, editing, and capturing payment data to construct Medicare outpatient groups for the future hospital outpatient prospective payment systems.

Important Instructions

The modifiers listed in this article are required on all Medicare claims for services furnished on or after July 1, 1998.

Two-digit modifiers should be appended to the appropriate HCPCS procedure code when the services performed are altered as indicated. Do not report the modifier by using a separate five-digit code (e.g., 09950, 09952) in addition to the procedure code.

Use CPT modifiers and/or HCPCS Level II modifiers listed below when appropriate for surgical procedures (CPT codes 10000-69999), radiology (CPT codes 70010-79999), and other diagnostic procedures (CPT codes 90700-99199).

CPT Modifiers

The following CPT modifiers should be used.

Modifier -50 ***(Bilateral Procedure)*** -- Use this modifier to report bilateral procedures that are performed at the same operative session as a single line item. Report the appropriate five-digit code describing the first procedure. Identify that a second (bilateral) procedure has been performed by adding modifier -50 to the procedure code.

Do not submit two line items to report a bilateral procedure. If one procedure is performed on the left and a different procedure -- with a different CPT code -- is performed on the right, a bilateral modifier should not be used since the same procedure was not performed bilaterally.

Note: The intermediary will reject the following surgical procedures if they are reported with modifier -50.

- Surgical procedures identified by terminology as "bilateral," e.g., 27395 (Lengthening of hamstring tendon; multiple, bilateral)
- Surgical procedures identified as "unilateral or bilateral," e.g., 52290 (Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral)

Modifier -52 ***(Reduced Services)*** -- Use this modifier to identify that a service or procedure was partially reduced or eliminated at the physician's election. Report the five-digit code identifying the service that was initiated and add modifier -52, signifying that the service was reduced.

HCFA reporting instructions: If a surgical procedure is terminated after the patient has been prepared for the surgery (including sedation when provided) and taken to the room where the procedure is to be performed, but before the induction of anesthesia (e.g. local, regional block(s), or general anesthesia), add modifier -52 to the intended procedure code (single line item). See modifier -53 for reporting instructions on surgical procedures terminated after anesthesia has been induced.

HCPCS Level II Modifiers

HCPCS Modifier	Code Description	Application listed in HCFA transmittal number 726
-E1	Upper left, eyelid	
-E2	Lower left, eyelid	
-E3	Upper right, eyelid	
-E4	Lower right, eyelid	
-FA	Left hand, thumb	
-F1	Left hand, second digit	
-F2	Left hand, third digit	
-F3	Left hand, fourth digit	
-F4	Left hand, fifth digit	
-F5	Right hand, thumb	
-F6	Right hand, second digit	
-F7	Right hand, third digit	
-F8	Right hand, fourth digit	
-F9	Right hand, fifth digit	
-LC	Left circumflex coronary artery	Hospitals use with codes 92980-92982, 92995, and 92996.
-LD	Left anterior descending coronary artery	Hospitals use with codes 92980-92982, 92995, and 92996.
-LT	Left side	Used to identify procedures performed on the left side of the body. *Do not* use LT and -RT to report bilateral procedures.
-QM	Ambulance service provided under arrangement by a provider of services	
-QN	Ambulance service furnished directly by a provider of services	
-RC	Right coronary artery	Hospitals use with codes 92980-92982, 92995, and 92996.
-RT	Right side	Used to identify procedures performed on the right side of the body. *Do not* use -RT and -LT to report bilateral procedures.
-TA	Left foot, great toe	
-T1	Left foot, second digit	
-T2	Left foot, third digit	
-T3	Left foot, fourth digit	
-T4	Left foot, fifth digit	
-T5	Right foot, great toe	
-T6	Right foot, second digit	
-T7	Right foot, third digit	

-T8	Right foot, fourth digit
-T9	Right foot, fifth digit

It should be noted that the description of modifier -52 in CPT 1998 does not include the HCFA reporting instructions above. Coders may want to add this information in their CPT book to ensure accurate use of this modifier for Medicare claims.

Modifier -53 ***(Discontinued Procedures)*** -- (Required only for discontinued surgical procedures as described below.) Under certain circumstances, a 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 (diagnostic or therapeutic) procedure was started but discontinued.

HCFA reporting instructions: If a procedure is terminated after the induction of anesthesia (e.g. local, regional block(s), or general anesthesia), or after the procedure was started (incision made, intubation begun, scope inserted), add modifier -53 to the intended procedure code (single line item). See modifier -52 for reporting instructions for surgical procedures terminated before anesthesia has been induced. Do not report the elective cancellation of a procedure.

It should be noted that the description of modifier -53 in CPT 1998 does not include the HCFA reporting instructions above. Coders may want to add this information in their CPT book to ensure accurate use of this modifier for Medicare claims.

Modifier -59 ***(Distinct Procedural Service)*** -- Use modifier -59 to identify procedures/services that are not normally reported together, but may be performed under certain circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. Use this modifier to indicate that a procedure or service was distinct or independent from other services performed on the same day.

HCFA reporting example:Procedures 23030 (Incision and drainage, shoulder area; deep abscess or hematoma) and 20103 (Exploration of penetrating wound [separate procedure]; extremity) are performed on the same patient on the same date of service. If these two codes are billed together without modifier -59, code 20103 would be denied as duplicate billing (since the incision and drainage of the shoulder is the definitive procedure, and exploration of the area preceding this is considered an inherent part of the procedure). If however, the exploration procedure was conducted on a different part of the same limb, or on a different limb, adding the -59 modifier to either code 20103 or code 23030 would explain the circumstances and prevent denial of the service.

Modifier -76 ***(Repeat Procedure by Same Physician)*** -- Use this modifier to indicate that a procedure or service was repeated in a separate operative session on the same day. Report the procedure once and then report it again, adding modifier -76 (two line items). Enter the number of times the procedure was repeated in the units field (except for ASC procedures, which are reported as indicated under exception below).

Note: HCFA's description of modifier -76 varies significantly from the definition in CPT 1998. Coders may want to add this information in their CPT book to ensure accurate use of this modifier for Medicare claims.

HCFA note:	This modifier (and modifier -77 below) may be reported for services ordered by physicians but performed by technicians.
HCFA example:	EKGs which have to be repeated due to changes in the patient's condition or the need to assess the effect of therapeutic procedures.
HCFA exception:	If the procedure is an ASC procedure, do not use the units field to indicate that the procedure was performed more than once on the same day. Report the HCPCS code without modifier -76 to indicate the first time the procedure was performed. For each additional time the procedure was performed, repeat the HCPCS code with modifier -76 added.

Modifier -77 ***(Repeat Procedure by Another Physician)*** -- Use this modifier to indicate that a basic procedure performed by another physician had to be repeated in a separate operative session on the same day. Report the procedure once and then report it again, adding modifier -77 (two line items). Enter the number of times the procedure was repeated in the units field (except for ASC procedures, which are reported as indicated under exception below). This modifier is similar to modifier -76 except that the same procedure was performed by a different physician.

HCFA exception:	If the procedure is an ASC procedure, do not use the units field to indicate that the procedure was performed more than once on the same day. Report the HCPCS code without modifier -77 to indicate the first time the procedure was performed. For each additional time the procedure was performed, repeat the HCPCS code, adding modifier -77.

It should also be noted that there may be occasions where more than one modifier may be used for one CPT code. In the case that two modifiers are required, the modifiers would be appended to the CPT code. In this example XXXXX represents the five-digit CPT code. If a procedure was performed on the right side and on the left side during the same operative session by the same doctor, but the right side had a procedure repeated the same day, code XXXXX50 and code XXXXXRT76 would be reported.

To learn more about these changes, look for AHIMA's audio seminar presentation "Modifiers for Hospital Coding: Meeting the New HCFA Requirements," June 11. For more information through FaxLink, call (888) 424-4040 and select order number 736, or call (312) 787-2672.

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