Modifier Usage for Hospital Outpatient Services

by Ann Zeisset, RHIT

Implementing the processes for CPT modifier usage in the outpatient hospital setting has been a topic on everyone's "to do" list since HCFA announced the change. There are many variables in executing this change, such as updating or changing computer systems, training staff, and developing changes in the facility chargemaster or order entry system.

Because the use of modifiers is integral to the new prospective payment system, HCFA will begin monitoring the appropriate usage of modifiers in hospitals. A recent transmittal released by HCFA provides clarification on using modifiers in reporting outpatient hospital services. The Program Memorandum answers questions that occurred after release of the previous transmittals (The Medicare Intermediary Manual [HCFA Pub. 13-3], Transmittal 1729 and the Medicare Hospital Manual [HCFA 748 Pub. 10], and Transmittal 726). The source for this article is the current HCFA transmittal No. A-99-41 dated September 1999.

Here are some general guidelines for modifier use for hospital outpatient services. These instructions are effective on April 1, 2000.

Not all HCPCS Codes Will Require Modifiers

- Do not use a modifier if the narrative definition of a code indicates multiple occurrences.

  EXAMPLES: The code definition indicates two to four lesions; The code indicates multiple extremities

- Do not use a modifier if the narrative definition of a code indicates that the procedure applies to different body parts.

  EXAMPLES: Code 11600 (Excision malignant lesion, trunks, arms, or legs; lesion diameter 0.5 cm. or less); Code 11640 (Excision malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm. or less)

- HCPCS level II Modifiers -GN, -GO, and -GP must be used to identify the therapist performing speech language therapy, occupational therapy, and physical therapy respectively.

- Modifiers -50 (bilateral), -52 (when used to indicate a discontinued procedure), -53, -73, and -74 apply only to surgical procedures.

Issues to Consider

The following are some general guidelines for using modifiers in the form of questions to be considered. If the answer to any of the following questions is yes, then it is appropriate to use the applicable modifier.

- Will the modifier add more information regarding the anatomic site of the procedure?

  EXAMPLE: Cataract surgery on the right or left eye

- Will the modifier help to eliminate the appearance of duplicate billing?

  EXAMPLE: Use modifier -77 to report the same procedure performed more than once on the same date of service but at different encounters

- Will a modifier help to eliminate the appearance of unbundling?

EXAMPLE: Codes Q0081 (Infusion therapy, using other than chemotherapeutic drugs, per visit) and 36000 (Introduction of needle or intra catheter, vein): If procedure 36000 was performed for a reason other than as part of the IV infusion, modifier -59 would be appropriate

Reporting Modifiers on the UB-92

- Modifiers are reported on the hard copy UB-92 (HCFA-1450) in field 44 next to the HCPCS code. There is space for two modifiers on the hard copy form (4 of the 9 positions). On the UB-92 flat file, providers use record type 61, field numbers 6 and 7. There is space for two modifiers, one in field 6 and one in field 7.
- On the electronic claim form, the segments SV202-03 and SV202-04 are used to report the two modifiers.
- Do not report the dash seen preceding a modifier.
- When it is appropriate to use a modifier, the most specific modifier should be used first. That is, when modifiers E1 through E4, FA through F9, LC, LD, RC, and TA through T9 apply, they should be used before modifiers LT, RT, or -59.

Use of Modifiers -50, -LT, and -RT

- Modifier -50 is used to report bilateral procedures that are performed at the same operative session as a single line item. Do not use modifiers RT and LT when modifier -50 applies. Do not submit two line items to report a bilateral procedure using modifier -50.
- Modifier -50 applies to any bilateral procedure performed on both sides at the same session.
- The bilateral modifier -50 is restricted to surgical procedures only (CPT codes 10040 to 69990). It is not required for radiology procedure codes or diagnostic procedure codes.
- Modifier -50 may not be used:

  - to report surgical procedures identified by their terminology as "bilateral"

  - to report surgical procedures identified by their terminology as "unilateral or bilateral"
- The unit entry to use when modifier -50 is reported is one.
- When modifier -50 is used, the reimbursement is for two procedures. If the procedure is an approved ambulatory surgery center (ASC) service, the multiple procedure rules apply. Because the procedures are in the same payment group, the ASC Pricer program calculates the payment at the full rate for one procedure, and 50 percent of the rate for the other procedure. Modifiers -LT and -RT
- Modifiers -LT or -RT apply to procedures performed on paired organs, e.g., ears, eyes, nostrils, kidneys, lungs, and ovaries.
- Modifiers -LT and -RT should be used when a procedure is performed on only one side.
- These modifiers are required whenever they are appropriate.

Use of Modifiers for Discontinued Services

In the proposed outpatient prospective payment system, reimbursement will be based on HCPCS coding. It was decided to implement modifiers for discontinued services so that hospitals would have a way under the new system to be reimbursed for expenses incurred in preparing a patient for surgery and scheduling a room for performing the procedure.

Modifier -52 was implemented for use when a procedure is terminated after a patient has been prepared for 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). Effective January 1, 1999, modifier -73 replaced modifier -52 for reporting these discontinued services.

Modifier -53 was implemented for use when 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 started, scope inserted). Effective January 1, 1999, modifier -74 replaced modifier -53 for reporting these discontinued services. Modifier -53 will no longer be an acceptable modifier for hospital reporting. The elective cancellation of a procedure should not be reported.

When used to indicate discontinued procedures, modifiers -73 and -74 are used for surgical and certain diagnostic procedures only. They are not used to indicate discontinued radiology procedures.

In the outpatient prospective payment system, when modifier -73 is reported and the procedure is an approved ASC service, payment will be 50 percent of the facility rate, subject to the ASC payment calculation. If modifier -74 is reported, there is no payment reduction.

If multiple procedures were planned and the procedure is terminated prior to completion, report the completed procedures as usual.

Other planned procedures that were not started are not reported. When none of the planned procedures are completed, the first planned procedure to be done is reported with modifier -73 or modifier -74, as appropriate. The others are not reported.

If a procedure is terminated prior to the induction of anesthesia and before the patient is wheeled into the procedure room, the procedure should not be reported. The patient has to be taken to the room where the procedure is to be performed in order to report modifier -52 or -73.

Modifiers for Repeat Procedures

The following two modifiers have been implemented for repeat procedures for hospital use:

- Modifier -76 is used to indicate that a procedure or service was repeated in a separate operative session on the same day by the same physician.
- Modifier -77 is used to indicate that a procedure or service was repeated in a separate operative session on the same day by another physician.

If there is a question regarding who the ordering physician was and whether or not the same physician ordered the second procedure, code based on whether or not the physician performing the procedure is the same.

The procedure must be the same. It is listed once and then listed again with the appropriate modifier.

Modifiers for Radiology Services

- Modifiers -52 (Reduced Services), -59, -76, and -77, and the Level II modifiers apply to radiology services.
- Modifiers -50, -52 (for indicating a terminated service based on the guidelines in transmittal 726) and -53, and the new modifiers -73 and -74 do **not** apply to radiology services.
- When a radiology procedure is reduced, the correct reporting is to code to the extent of the procedure performed. If no code exists for what has been done, report the intended code with modifier -52 appended.

  EXAMPLE: Code 71020 (Radiologic examination, chest, two views, frontal and lateral) is ordered. Only one view is performed. Report code 71010 (Radiologic examination, chest: single view, frontal). Do not report code 71020-52
- At this time there are no payment reductions for radiology services reported with modifier -52 (Reduced Services). Payment will still be the least of the reasonable cost, customary charge, or blended amount.

HCPCS Level II Modifiers

- Generally, these codes are required to add specificity to the reporting of procedures performed on eyelids, fingers, toes, and arteries.
- They may be appended to CPT codes.
- If more than one level II modifier applies, repeat the HCPCS code on another line with the appropriate level II modifier.

  EXAMPLE: Code 26010 (drainage of finger abscess; simple) done on the left-hand thumb and second finger would be coded:

  - 26010FA

  - 26010F1
- The Level II modifiers apply whether Medicare is the primary or secondary payer.

Previous modifier information and instructions were published by HCFA in the *Medicare Intermediary Manual* (HCFA Pub. 13-3), Transmittal 1729, and the *Medicare Hospital Manual* (HCFA Pub. 10), and Transmittal 726. These transmittals were dated January 1998 and were effective July 1, 1998. These are available in your Medicare manuals or at www.hcfa.gov/pubforms/transmit/transmit.htm. The hospital manual (HCFA Pub. 10) is also available at www.hcfa.gov/ as well as an index. Facilities received a letter dated June 18, 1998, with instructions regarding implementation. Hospitals were notified that modifier usage would be accepted, but a full implementation was being delayed.

Transmittal No. A-99-41 clarifies and updates previous information. Appropriate modifier usage is to be implemented by April 1, 2000. Questions can be directed to the HCFA contact person identified on the transmittal.

A copy of the Program Memorandum is available at www.hcfa.gov/pubforms/transmit/A994160.htm.

References

Medicaid and Medicare 1999 Program Memos, Transmittal No. A-99-41, Clarification of Modifier Usage in Reporting Outpatient Hospital Services, September 1999, available at www.hcfa.gov/pubforms/transmit/A994160.htm.

Transmittal Adds Modifiers

Transmittal A-00-07 was released by HCFA in February 2000. This transmittal lists newly approved modifiers for hospital outpatient use and also corrections to the Program Memorandum A-99-41 discussed in this article.

Effective April 1, 2000, modifiers 25, 58, 78, and 79 will be approved for hospital outpatient use. This memorandum lists all approved modifiers for use by hospitals

The use of modifiers applies to services/procedures performed on the same calendar day.

The correction states that the language allowing five modifiers per CPT code is to be disregarded, and that Medicare will currently only allow two modifiers per CPT code.

This transmittal, which goes into effect April 1, 2000, is available at www.hcfa.gov/pubforms/transmit/A000760.pdf.

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