Understanding Surgical Modifiers

Modifiers: Make sure you use the right one!
- Assure carrier consideration to special circumstances.
- Use of modifiers that apply to major and minor procedures.
- May result in payment denials if not used.
- May result in payment denials if the wrong modifier is used.

Global Surgical Days
- Minor Procedure
  - Total global period
    - Zero days
    - Ten days
  - No preoperative period
- Visits on day of procedure generally not payable
  - Unless of different condition
- Modifier 25 needed if applicable
Global Surgical Days

- Major Procedures
  - Total global period is 90 days
  - Day before the day of surgery
  - Day of surgery
  - 90 days immediately following the day of surgery
  - Preoperative period is one day
  - Intra-operative period is day of surgery
  - Post operative period is 90 days
  - Counting from the day after surgery

Services Included in the Global Surgery Package

- Post-Operative Days
  - Follow up visits related to recovery from surgery
  - Post surgical pain management by surgeon
  - Miscellaneous Services
    - Dressing change
    - Suture and staple removal
    - Bedside minor procedure

Services Not Included In the Global Surgery Package

- Initial Consultation
- Evaluation determine need for surgery
- Services of other physician
  - Visits unrelated to the diagnosis for which the surgical procedure is performed
- Related surgical procedure resulting in a return to the operating room
- More extensive procedure required
- Diagnostic tests and procedures
- Non related surgical procedure
- Immunotherapy management
  - Critical care service unrelated to the surgery
Modifier 22

- Unusual Procedural Services
  - Surgeries for which services performed are significantly greater than usually required may be billed with modifier 22.
  - Bill modifier 22 with the CPT code for the procedure performed.

Unusual Procedural Services Cont.

- Sufficiently document services billed with modifier 22 to support the service furnished was significantly greater than usually required. Supporting documentation must include an operative report and statement on how the services furnished differ from the usual services furnished. Include in electronic submissions a statement that documentation is available in the extra narrative field.
- Modifier 22 may be used to document only services with 000, 010, 090 or YYY global periods on the Medicare Physician Fee Schedule. See the Medicare Physician Fee Schedule.

Modifier 50

- Bilateral Procedure
  - Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day.
  - Check the MPFSDB to be sure the surgical code is billable as bilateral. Checking the "Bill Surg" column on the database.
  - The following MPFSDB indicators show which procedures Medicare accepts with a modifier 50.
    - "0" indicates a unilateral code; Modifier 50 is not billable.
    - "1" indicates modifier 50 can be appropriate.
Bilateral Procedure Cont.

- "2" indicates a bilateral code; modifier 50 is not billable.
- "3" indicates primary radiology codes; modifier 50 is billable.
- "9" indicates that the concept does not apply. (office visit)
- The CPT book specifies that a service could be unilateral, bilateral, or c. unilateral or bilateral. This modifier is not appropriate on codes where the CPT specifies b or c.
- Inappropriately use receives an unprocessable denial message.

Modifier 51

- Multiple Surgeries/Procedures
  - Multiple surgeries performed on the same day, during the same surgical session.
  - Diagnostic Imaging Services subject to the Multiple Procedure Payment Reduction that are provided on the same day, during the same session by the same provider.

Multiple Surgeries/Procedures Cont.

- Modifier is appended when:
  - The same physician performs more than one surgical service at the same session (Indicator 2).
  - The technical component of multiple diagnostic procedures, Multiple Procedure Payment Reduction (MPPR) rule applies (Indicator 4).
  - The multiple surgical procedures are done on same day but billed on two separate claims.
  - The surgical procedure code is the lower physician fee schedule amount.
  - The diagnostic imaging procedure with the lower technical component fee schedule amount.
Multiple Surgeries/Procedures Cont.

- Do not append to add-on codes (See Appendix D of the CPT manual)
- Do not report on all lines of service.
- Do not append when two or more physicians each perform distinctly, different, unrelated surgeries on the same day to the same patient.

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Modifier 52

- Reduced Service
  - Surgeries for which services performed are significantly less than usually required are billable with modifier 52.
  - Bill modifier 52 with the CPT code furnished service.
  - Sufficiently document services billed with modifier 52 to support services furnished was less than usually required.

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Modifier 54

- Surgical Care Only
  - Modifier 54 indicates the surgeon is relinquishing all or part of the postoperative care to a physician outside the same group.
  - Bill modifier 54 with the CPT code describing services furnished.
  - Applies to MPFSDB codes that include 010 or 090 global periods.
  - CMS defines the modifier 54 differently than CPT 4 by including reimbursement of all preoperative care, the inoperative surgical service, and all hospital postoperative care.
Surgical Care Only Cont.

- The surgeon must keep a copy of the written transfer agreement in the beneficiary's medical record.
- Modifier 54 does not apply to assistant at surgery services.
- Modifier 54 does not apply to Ambulatory Surgical Center's facility fees.

Modifier 55

- Postoperative Management Only
  - The surgeon who furnished a portion of the outpatient postoperative care and the physician, other than the surgeon, who furnished postoperative management services bill with the 55 modifier.
  - Bill modifier 55 with the CPT code describing the surgical procedure.
  - Bill modifier 55 for procedure codes with MPFSDB global periods of 010 or 090.
  - Codes billed must show the date of surgery as the date of service, also indicate the date care was relinquished/assumed.

Postoperative Management Only Cont.

- Keep copies of the written transfer agreement in the physician furnishing the postoperative care beneficiary's medical record.
- Provide at least one service before the receiving physician can bill for any part of the postoperative care.
- Not appropriate for assistant at surgery services.
- Not appropriate for Ambulatory Surgical Center's facility fees.
Modifier 56

- Preoperative Management Only
  When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure.

- Use with surgical codes only to indicate that only the pre-operative care was performed.

- Do not submit modifier 56 on CPT codes that has 0 days Global period.

- Do not submit modifier 56 on E & M services.

- Do not submit modifier 56 along with other Global Surgical split billing modifiers 54 and 55.

- Do not submit modifier 56 along with modifiers 80 (Assistant Surgeon), 81 (Other Assistant Surgeon), 82 (Assistant Surgeon after Qualified resident surgery not available and 45 (Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistance at surgery, non-team member).

Source: [http://www.cptcousa.com/coding/modifiers.htm](http://www.cptcousa.com/coding/modifiers.htm)

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Modifier 59

- Distinct Procedural Service
  Modifier 59 indicates a procedure or service was distinct or separate from other services performed on the same day.

- Represented by a different session or patient encounter, different procedure or surgery, different site, separate session, or separate injury (or area of injury).

- Modifier 59 indicates the secondary, additional, or lesser procedure.


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Distinct Procedural Service Cont.

- Modifier 59 is not valid on E/M Codes.

- Use modifier 59 if no other valid modifier exists. I.E. CMS established modifiers indicating services provided on the same date to different anatomic sites (i.e., for eyelids, E1 through E4; for fingers FA, and F1 through F9; for toes, TA, and T1 through T9; LT and RT).

Modifier 60

- Complicated Surgeries
  - should be used when a procedure is significantly more surgical or requires more time as a result of:
  - previous surgeries
  - significant scarring, adhesions, or inflammation;
  - distortion of the anatomy
  - irradiation
  - infection
  - trauma
  - very low birth weight (i.e., neonates and small infants weighing less than 10 kg).

Modifier 62

- Two Surgeons
  - When two surgeons work together as primary surgeons performing distinct parts of a procedure, each surgeon should report the co-surgery once using the same procedure code and report his/her distinct operative work by adding modifier 62 and any associated add-on code(s) for that procedure.
  - If additional procedure(s), including add-on procedures, are performed during the same surgical session, separate codes may also be reported with modifier 62 added.
  - Per the AMA rules, you cannot append modifier 62 to the instrumentation or grafting codes.

Two Surgeons Cont.

- If a co-surgeon acts as an assistant in performing additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with the modifier 80 or modifier 82 added.
- Do not report an 80 modifier with a 62 modifier when two surgeons are working together on co-surgery. It is implied within the description of the 62 modifier that each surgeon will be "assisting" with the procedure.
Two Surgeons Cont.
- Report both the 62 modifier and the 50 modifier (bilateral procedure) when co-surgery is done by surgeons of the same specialty.
- Append the 62 modifier to add-on codes the same way you would with any other co-surgery service.
- Communicate with the staff of the other surgeon billing co-surgery so claims are submitted in the same time frame.

Modifier 76
- Repeat Procedure by Same Physician
  - Repeat procedures performed on the same day.
  - Indicate that a procedure or service was repeated subsequent to the original procedure or service.
  - The same physician performs the services.
  - Procedure codes that cannot be quantity billed.

Modifier 77
- Repeat Procedure by Another Physician
  - Report the same service provided by another physician.
  - Indicate that a basic procedure or service had to be repeated.
  - Report each procedure on separate lines.
  - List the procedure code once by itself and then again with modifier 77.
  - Do not use the units' field to indicate the procedure was performed more than once on the same day.
  - Add modifier 77 when billing for multiple services on a single day and the service cannot be quantity billed.
Modifier 78

- Return To The Operating Room For A Related Procedure During The Post Operative Period
  - Used to indicate the performance of a procedure during the postoperative period or on the same day as the original procedure to treat complications, which required return to the operating room.
  - Bill modifier 78 with the CPT code describing the procedure(s) performed during the return trip.

Return To The Operating Room...Cont.

- Only use the procedure code for the original procedure if the identical procedure is repeated.
- When the procedure code used to describe a service for treatment of complications is the same as the procedure code used in the original procedure, modifier 78 is still the correct modifier to use.
- Modifier 78 reimbursement is intra-operative percentage only.
- Use Modifier 78 to document treatment of complications only.

Return To The Operating Room...Cont.

- Use Modifier 78 to indicate services furnished in an operating room (OR). OR definition, for this purpose, is a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, laser suite, or endoscopy suite. It does not include a patient's room, minor treatment room, recovery room, or intensive care unit.
- Does not apply to assistant at surgery services.
- Does not apply to Ambulatory Surgical Centers facility fees.
Modifier 79

- Unrelated Procedure or Service by the Same Physician During the Postoperative Period
  - Modifier 79 indicates the performance of a procedure or service during a post-operative period was unrelated to the post-operative care of the original procedure.
  - Bill Modifier 79 with the procedure performed.
  - Do not bill when the MPFSDB indicating XXX in the post-operative field.

Unrelated Procedure or Service...Cont.

- Use modifier 79 on services during the post-operative period starting the day after the procedure.
- Does not apply to assistant at surgery services.
- Does not apply to Ambulatory Surgical Center's facility fees.

Modifier 80

- Assistant Surgeon
  - Provides full assistance to the primary surgeon.
  - Capable of taking over the surgery should the primary surgeon become incapacitated.
  - Reimbursement will be 20% of the provider's applicable Fee Schedule allowed amount for the primary surgery.
Modifier 81

- Minimum Assistant Surgeon
  - An assistant who does not participate in the entire procedure but provides minimal assistance to the primary surgeon.
- Reimbursement will be 10% of the provider's applicable Fee Schedule allowed amount for the primary surgery.

Modifier 82

- Assistant Surgeon (when qualified resident surgeon not available)
  - In certain programs or facilities (e.g., in teaching hospitals), the physician who generally acts as the assistant surgeon is a qualified resident surgeon. There may be times when a qualified resident surgeon is not available to assist the operating surgeon, so a physician assists the operating surgeon in this instance.
- This modifier is not intended for use by non-physicians assisting at surgery (e.g. Nurse Practitioners, Physician Assistants, Registered Nurse First Assistants, etc.).

Questions?