

## HB 10-1332 Colorado Medical Clean Claims Transparency and Uniformity Act Task Force

### Agenda

October 23, 2012, noon - 6 PM MST

October 24, 2012, 7:30 AM - 3 PM MST

Location: COPIC Boardroom, 7351 E. Lowry Blvd. #100, Denver CO 80230

(See directions on the last page of agenda)

Call-in number: 1-866-740-1260, ID 8586314 #

Tuesday Web Login: <https://cc.readytalk.com/r/vzpd9h28butt>

Wednesday Web Login: <https://cc.readytalk.com/r/ucxfotbz34ib>

### **Agenda**

#### **October 23, 2012**

12 - 12:30 PM Lunch

12:30 – 12:45 PM Roll call, welcoming remarks and housekeeping

- Approve September 2012 meeting minutes (Attachment A)

#### **Committee Reports**

***Committee Reports: introduce committee members; committee principles (if applicable); committee scope of work; report of activities to date; recommendations (draft and final); issues to be resolved or investigated; questions for the full task force; next steps.***

12:45 - 1:15 PM Finance – Barry Keene/Foundations Meeting

- State Innovation Model (SIM) Grant Application
- Other Financial Update

1:15 – 2:45 PM Data Sustaining Repository – Mark Rieger/Val Clark

- Discussion of DSR Long Term Business Model Update (Attachment B)

2:45 - 3:15 PM Specialty Society – Tammy Banks/Helen Campbell

3:15 - 4:30 PM Edit– Beth Wright/Mark Painter

- Modifier Table Progress (Attachment C)

4:30 – 6:00 PM Refreshments and Casual Conversation Regarding Making Rules vs. Edits

6:00 PM Adjourn for the Day

**October 24, 2012**

7:30 - 8:00 AM	Breakfast
8:00 – 10:00 AM	Rules Committee – Lisa Lipinski
10 - 10:15 AM	Break
10:15 - 11:45 AM	Review of Draft Task Force Report to the Legislature (Attachment D to be sent prior to meeting)
11:45 AM - 12:15 PM	Lunch
12:15 PM - 2:30 PM	Review of Draft Task Force Report to the Legislature (continued)
2:30 - 2:50 PM	Other Business <ul style="list-style-type: none"><li>• Future Meeting Schedule</li></ul>
2:50 - 3:00 PM	Public Comment
3:00 PM	ADJOURNMENT

# Attachment A

## DRAFT

### HB10\_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT TASK FORCE

Meeting Minutes

September 26, 2012

Noon - 2 PM, MST

Call-in Number: 1-866-740-1260

Conference ID: ID 8586328

#### Attendees:

- Amy Hodges
- Barry Keene, CC
- Dee Cole
- Doug Moeller, MD
- Fred Tolin, MD
- Helen Campbell
- Jill Roberson
- James Borgstede
- Kathy McCreary, MD
- Kim Davis
- Lori Marden
- Marie Mindeman
- Marilyn Rissmiller, CC
- Mark Painter
- Mark Rieger
- Nancy Steinke
- Ryshell Schrader
- Tammy Banks
- Tom Darr, MD
- Wendi Healy

#### Staff :

- Laura Powers
- Barbara Yondorf

#### Public:

Diane Hayak  
Geraldine McGinty  
Lisa Lipinski  
Pam Kassing

#### Meeting Objective (s):

##### Key:

- TF = Task Force
- TFM = Task Force Member
- CC = Co-Chair

##### Parking Lot:



<b>TOPIC</b>	<b>DISCUSSION</b>	<b>ACTION ITEM</b>	<b>DUE DATE</b>
<p><b>Welcome &amp; Roll Call &amp; Housekeeping</b></p>	<p><b>ROLL CALL &amp; WELCOME:</b> 20 Task force Members in attendance, quorum met</p> <p><b>Approve August 2012 meeting minutes (Attachment A)</b> The minutes were approved. Moved to approve by Barry, and seconded by Wendi.</p> <p><b>2012 Meeting Schedule</b></p> <p>Marilyn: October 23<sup>rd</sup> at noon is the next in person meeting.</p> <p>Barry: Yes will start with lunch and continue into the afternoon. The 24<sup>th</sup> will start in the morning and continue into the afternoon.</p> <p>Marilyn: Barb has a conflict for the November meeting and wondered if we could move the meeting to 10-12 MST for the November date instead of the originally scheduled noon-2pm MST.</p> <p>Barry: Since Barb is working on the legislative report, this is critical.</p>	<p><b>A note will be sent to see if the November 14 meeting can be moved to 10-noon MST</b></p>	<p><b>Prior to October meeting</b></p>
<p><b>Committee Reports</b></p>	<p><b>DSR (DATA SUSTAINING REPOSITORY)- MARK RIEGER</b></p> <p>Mark Rieger: We believe that our charge during our last DSR meeting was to prime the pump for possible self-sustaining models for the work product we create. We started with a review regarding the important assumptions. There won't be any public funding on a sustainable basis. People need to be able to access this information. This will not be the work of this group to manage this implementation. Jumped off from that context for what kind of business models might be possible. We looked at the main approaches.</p> <ul style="list-style-type: none"> <li>• One being free market approach in which we allow market to determine whether this entity would be viable. Shift the risk to the private sector. Figure out how to get money out of the private sector and expectations need to be delivered. We shift the risk to the private sector and the pricing would not be under the direct control of government.</li> </ul>		

Barry: Question on F – what does that mean.

Mark R: We have created a document available to the market. While a payer will have to use set of rules, you don't have to require that the payer must purchase something. How is vendor going to sustain infrastructure. Worst case scenario no one wants to pay but they need the info.

- Public utility option: add a modicum of public control. The state reviews the way these services are priced. The state want to make sure access is not impaired. We don't allow free market to set the price. We tell the state, we think this is the price that is required. That provides certainty in the price model but a disadvantage that it does not allow the vendor to see what the market will bear. This may require a new law being created that creates that mandate for the trading partners. They marketplace may only have a single vendor choice. If you process claims, you are required to purchase this information from this vendor but there is regulation with the pricing of the service.
- Foundation Mode: Not necessarily holding high hopes that this is an option.
- Also possible to piggyback on all-payer claims database.

James: Would you envision that physicians would be paying for the free market model?

Mark R: There would be no requirement to use this service. Anyone who needs to use this rule set would be a possible user (payers, providers, etc).

Barry: This is about rule set and how to use the rule set. Somewhere there has to be a place where people can access this edit set. It will be public domain but how you go about using the edit set is up to you. For example using software with automatic updates, etc. then you are paying for that in billing software. It may be that payers are picking up part of it. People using the data are the ones who are going to be interested.

	<p>Mark R: The free market option is risky so you could also ask for legislation mandating this.</p> <p>Barb: We have several consensus items we need to get through. Can we table this discussion so we can move forward on these other agenda items?</p> <p>Barry: Potentially move onwards and clarify at the October meeting.</p>	<p><b>Continue DSR Model Discussion</b></p>	<p><b>October Meeting</b></p>
	<p><b>EDIT COMMITTEE – BETH WRIGHT/MARK PAINTER</b></p> <p>Mark Painter: What we have been doing is going through the modifier table to determine whether it is a payment modifier and tying back to A through P table and then looking at ways that information is currently handled by payers right now. Example modifier 22 it is a payment modifier, does not override existing edits and does require additional documentation to be submitted for review. Some payers pend this as it comes in and some pay a flat percentage. We have gone through all of the CPT modifiers and our next task is to go through all the HCPC modifiers.</p> <p>Lisa: The last columns are CPT (Column 4) and CMS guidelines (Column 5).</p> <p>Mark P: Yes these are really just informational only. We have been working with the rules committee and the Rules Committee created this table.</p> <p>Marilyn: Any questions for Mark on modifier process?</p> <p>Then we need to get the HCPC into a similar table and go through the HCPC modifiers.</p>		

**RULES COMMITTEE – LISA LIPINSKI/HELEN CAMPBELL**

Lisa: Yes here with Helen. Looking at Attachment D. This is a document that explains the RBRVS (Resource-Based Relative Value Scale) so that we can explain our definitions.

Pricing definitions and guidelines as listed below:

*“Pricing rules” globally are defined to mean payment rules applied by a health plan or its agent to increase or decrease the agreed fee schedule amount (but not decreased to \$0) in specified circumstances.*

*Pricing rules considered in scope for discussion are contained within the CO legislation (Bill HB10\_1332), such as when several procedures are done at the same time (multiple procedure reduction logic), the designated bilateral procedure is done on both sides of the body (bilateral modifier payment percentage), the service is provided by an assistant surgeon (assistant at surgery payment percentage), services are included within a global period or global procedure, etc. View the CO legislation for a full listing of procedures.*

Barb: Would like to open for comments and questions.

James: We’ve talked multiple times about multiple procedural reduction and how it applies for radiology and I would object to this for professional services because there is no logic for this on professional service. We have data that there is no cost savings. For a CT of the chest and abdomen there is no cost savings. This should be reviewed as correct coding but it shouldn’t be for payment reduction.

Barb: Are you suggesting an amendment to this?

James: Yes, I would propose for radiology for a professional component apply only for presenting a clean claim but not for payment reduction.

Tammy: The point of this is to discuss these issues. We are looking at pros and cons, not looking to bring this forward yet.

Barb: Can we get a consensus that this does work? This is a consensus but nothing is final until the final report.

Nancy: Can someone comment that there is a discrepancy in the first and second paragraph of not reducing to \$0 but then adding the global procedure reduction would bring it to a zero dollar payment.

Tammy: When we are looking at the global period we are looking at the modifier that will either increase or decrease. We are looking at that as a coding rule which is part of a pricing rule.

Nancy: I can use modifier 24 with an E & M to override a global edit. Rather than the code in column 1 would get a zero amount when billed in column 2.

Mark R: Another possibility is that you meant the pre and post-operative component of the global surgery rate. That is a pricing rule but denying is an edit. When I read it the first time I read it as a pre and post op modifier adjustments to the global rate.

Kim: I don't think the legislation lists procedures.

Marilyn: Yes they are payment rules but it is not a complete list.

Tammy: Perhaps change the language to payment rules.

Barb: Take out full and confusion regarding \$0. Does that require a language change or just add a discussion point.

Kim: There is only a mention of decreasing but sometimes payment rules can increase as well. Suggest modifiers that influence payment up or down.

Barb: Can you give us an example of what to add.

Wendi: Maybe used increased procedural?

Kim: We don't have to use modifier 22, that is just an example.

Marilyn: What is a pricing rule?

Mark R: Not all pricing rules require a modifier. I think we are getting a little pedantic. It is not intended to create a complete list of pricing rules.

Barb: That first sentence is good. Two questions, in the next sentence with examples, do we want to include modifiers.

Kim: Maybe no examples would be better.

Barb: Proposing the following amended language:

*“Pricing rules” globally are defined to mean payment rules applied by a health plan or its agent to increase or decrease the agreed fee schedule amount (but not decreased to \$0) in specified circumstances.*

*Pricing rules considered in scope for discussion are contained within the CO legislation (Bill HB10\_1332. View the CO legislation for a listing of payment rules.*

---

→ **CONSENSUS: AS LISTED ABOVE**

Lori: Nancy you had a concern about a payment rule not increased to zero. Are you still concerned with this?

**IMPORTANT NOTE** Nancy: As long as I know it is not talking about the edit itself but the ability to override the edit then I am fine.

James: Objections noted.

Lisa: Moving to 2<sup>nd</sup> item, payment rule guidelines.

**Payment rule guidelines**

- *The purpose of pricing rules is to move toward a uniform, transparent practice in the marketplace.*
- *The Medicare pricing rules based on the RBRVS are recommended for the starting point of the discussion for the development of a national payment rule standard because they are already widely used by both public and private payers and maintain the relativity of the Medicare RBRVS.*
- *Pricing rules should not include cost containment, political influences or benefit limitations.*
- *The pricing rules must not affect payers’ ability to negotiate and agreed upon contracted rate with physicians and other health care providers for the performance of medical procedures and services.*
- *The pricing rules only standardize the way payment rules are applied to those negotiated fee-schedules.*

Lori: 2<sup>nd</sup> bullet reference national payment rule so wondered about that since this is a Colorado task force.

Marilyn: We are developing Colorado Standardized set.

Geraldine: Multiple Procedural Reduction distorts the relativity that is in the RBRVS and it is a political statement and there are no efficiencies. We don't support current Medicare Policy.

Marilyn: Lisa is saying there are lots of variations on the guidelines and we are just looking at this as a starting point. We are taking other sources into consideration. As the third bullet states, we are not looking to include any rules that are cost containment, political influences, or benefit limitations.

Barb: Any questions?

Tom: Is Medicare subject to these rules in Colorado?

Marilyn: They are not.

Lisa: 4<sup>th</sup> bullet "and" should read "an" to read "an agreed upon contracted rate."

Barb: any other comments or proposals. Asking for consensus with two changes: Bullet two change national to Colorado and change and to an in bullet 4.

---

→ **CONSENSUS:**

**Payment rule guidelines**

- *The purpose of pricing rules is to move toward a uniform, transparent practice in the marketplace.*
- *The Medicare pricing rules based on the RBRVS are recommended for the starting point of the discussion for the development of a Colorado payment rule standard because they are already widely used by both public and private payers and maintain the relativity of the Medicare RBRVS.*
- *Pricing rules should not include cost containment, political influences or benefit limitations.*
- *The pricing rules must not affect payers' ability to negotiate an agreed upon contracted rate with physicians and other health care providers for the performance of medical procedures and services.*
- *The pricing rules only standardize the way payment rules are applied to those negotiated fee-schedules.*

Barb: looking at the charge.

Lisa: The charge is to bring forward pricing rules guidelines as below.

*I. Pricing rule guidelines are approved as listed above.*

*II. Rules work group is charged with bringing forward pricing rule recommendations that meet the above stated guidelines and legislation requirements.*

Barb: anyone who has a question or comment or do we have consensus?

---

→ **CONSENSUS: AS LISTED ABOVE**

Lisa: Looking at modifier definition:

***Modifier definition***

*A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities. Documentation of special circumstances is sometimes required by the payer to receive full reimbursement on the claim, but guidelines vary from payer to payer.*

Barb: Any discussion on that?

Mark P: Is this relating only to payment modifiers? Does that first sentence also clarify that it could be a site for example right or left.

Lisa: This is just the CPT definition.

Mark P: Not going to address HCPC modifiers then?

Marilyn: We're talking about all the modifiers and maybe we need to add some to the description to add the other modifiers. Those are usually just informational, right?

Mark P: Some don't alter the circumstance, they just clarify.

Nancy: The Edit Committee is still going to be looking at the HCPC modifiers. This group only needs to look at them when they modify payment.

Mark R: What purpose does having a definition serve for what the respective groups are working on? We are looking at pricing rules and edit rule. If rule and methods of the rule requires specific coding whether the procedure code or the modifier then that is contained in the rule. We already have a list of modifiers and procedure codes and it is the use of those that contains the definition. Do we need a definition of a procedure code then?

Lisa: This is a part of the HCPC definition of modifiers.

Tammy: This occurred because we wanted to look at additional modifiers that could have an effect on pricing rules including HCPC codes. Wanted modifier definition to have further clarification.

Mark R: What are pricing rules that work group can work on. We don't want modifiers, we want pricing rules.

Mark P: Is this only payment modifier?

Marilyn: We are talking about all modifiers and maybe we need to add a description about the HCPCs modifiers.

Nancy: Payment group only needs to look at these when it affects payment.

Mark R: What purpose do we have to identify a modifier definition? Already have a mandates list of modifiers and mandates list or rules. Do we need this? Logic would say we also need a definition for a procedure code.

Marilyn: Do we need a modifier definition?

Tammy: Lisa is going to bring forth any other modifiers that could affect pricing. We wanted this to add clarification to add their thoughts.

Mark R: What are the pricing rules we should be working on, not a list of modifiers. Better served by giving a list of the rules. I am happy to describe all the payment rules we have.

Marilyn: Edit committee has been working on definitions around P, modifiers that affect payment rules. Maybe the rules committee just focuses on the rules and leaves it at that.

Barb: Rather than asking for consensus, ask for this modifier definition, note where it came from and just share this with the Edit Committee that is working on modifiers.

Lisa: Wants to ask if Rules Committee is alright with that.

Helen: Yes

Mark R: We might all want to have consensus that the implementation of a rule cannot conflict with the HCPC or CPT definition of a modifier.

Barb: Hearing that it is ok, but that we will share with Edit Committee.

Wendi: Can we just add to the part about the payment committee charge. We went around some of what the modifier does. We were trying to further define payment rule guidelines.

Marilyn: It sounds like we need to bring back the Edit Committee and the Payment Rules Committee together. I think once the Edit Committee goes through their process and tying modifiers to edit types it will make more sense.

Lisa: There should be no payment rules that conflict with HCPC and CPT as well.

Barb: Take this conversation and reflect it in the minutes, that is good enough.

Lisa: that is fine.

Lisa: Also working on a document on pros and cons and looking now at bilateral modifier. Ready to discuss at the October on-site meeting. Looking to see if payer systems to see if bilateral modifier can be used on a single line or be split into two. We do have a couple of asks as follows:

- *If payer systems have the capability to allow a bilateral modifier to be reported on a single line and then be split to two lines if their systems require it.*
- *Any costs incurred in relation to the bilateral modifier - 50. This includes costs related to reconsiderations, claim appeals, overpayment recoveries, as well as how many calls are received related to reporting of the bilateral modifier.*
- *Any other information concerning the bilateral modifier that would be useful to our discussions.*

Barry and Barb: Commended Lisa for her work in this area. Helen also thanked for being co-chair.

**Bring this Edit Committee**

**Payers were asked for input**

**SPECIALTY SOCIETY – TAMMY BANKS/HELEN CAMPBELL**

Barry: Want to chime in that Dr. Borgstede has joined and has been active immediately. We haven't had a lot of engagement from doctors aside from those who are on task force and work for an insurance company or software company. I am pleased now that we have a member of a specialty society on the task force. Marilyn and I have asked Dr. Borgstede to help with reaching out to members of specialty societies. We have asked him to join this committee. We are going to have growing input from this committee.

Marilyn: In the process of having a Colorado communication, we will include that Dr. Borgstede is able to help us.

James: Thank you for the opportunity.

Tammy: Marilyn has been wonderful. Once the letter goes out in Colorado, we will also send out to National Medical Specialty Societies since there may be some Colorado members who could benefit from the communication.

**PROJECT MANAGEMENT- BARRY KEENE**

Barry: Looking at attachment E.

Barb: Just developed a very basic skeleton for what I thought would be the very basic components. It is structured around legislation. The distinction between the base and a fully developed set doesn't really make sense so we will note that in the progress report. Form should follow function. We have another report in a year and that will be in the final report. Thoughts about what will be attached in appendices; just keeping track of what we might want to include in the final report. Two audiences here. One is the legislature and health care policy and financing and we also want to note what has worked and what has not for the national initiative. Over the next month, we may be sending out pieces of this and I may be asking for some help to see if I am on the right track.

Barry: So happy that we are having Barb on this. We do have some things to explain. While we are compliant with the legislation, the way we got there is a little bit convoluted.

**FINANCE – BARRY KEENE**

Barry: RFP, or the data analytics portion. The draft is now at the website in the member's only section. We got a lot of help from the state as to whether we needed to follow state procurement rules, we do not. We also had some subordinate questions regarding possible funds received via the SIM grant. We found out we did not need to follow their procurement rules. HCPCs also offered to put the RFP in their format and to run it for us. They have taken out irrelevant elements and what we have now is a document that is robust and has some open pieces. It has flags where we have questions. I also need to know whether there are things we are missing. I would like to have input as soon as possible. This should be ready to go out to potential vendors very soon. The state has also offered to help with the scoring committee which we may do depending on the timing.

James: Can you send it to me please.

Barry: Yes though you can download it as well. I look forward to your comments. We do not have the funding in place to procure this at the moment. We are looking to the fiscal sponsor to see if we can send this without the funding in place.

Any comments or questions?

	<p><b>FINANCE COMMITTEE:</b></p> <p>Barry: We were asked to participate in the State Innovation Model grant application, Data Integration &amp; Quality Work Group and we have been included in the Colorado Application for the State Innovation Model (SIM) Grant. This is what Sue Birch mentioned during the July meeting. There are 5 grants that will be issued and it is a very competitive environment for all the states. There is a lot of optimism regarding Colorado's viability and I am looking forward to hearing about this. The awards are meant to be announced in mid-November. We should hear in mid-November whether Colorado has won an award.</p> <p>If so, we are considered to be one of the budget line items. I have been in conversations with people at CMS pushing on them about where they are on sec, 10109 on edit transparency and uniformity. Those recommendations were supposed to be forthcoming and keep getting pushed back. Have communicated with Loraine Doo and in that communication, she indicated that we are well-known in this circle.</p>		
	<p>Foundation application is less positive but not a disaster. The Colorado Health Foundation responded to our application and is supportive of our work but they have chosen not to fund at this time. The first reason is they do not like to overlap grants and our current grant runs through January 2013. They have suggested we reapply. The second thing is before we come aboard for our next round of funding, they want to see the response from HCPC and the legislature to our report. I mentioned that it was HCPC that encouraged us to apply for the SIM grant. The legislature backed this with heavy bipartisan support so we have every expectation that this will be received positively so I did not push too hard. In the business world, it is easy to ask what is <del>isn't</del> the problem here but this is harder to do with our foundation contact. I don't know who on this board wanted to see what the legislature thought of this. I don't have a good idea what they are concerned about but they did encourage us to reapply.</p> <p>Did get a response from the Colorado Trust that if the Colorado Health Foundation got back on board, they would likely do so as well.</p> <p>Lastly, I'd like to report that we are pleased that Cigna has become one of our backers. They have pledged and we are working on that invoice. We have now received contributions from almost all the payers.</p>		

	<p><b>OTHER BUSINESS</b></p> <p>Marilyn: Any other business?</p> <p>Tom: Where is next meeting?</p> <p>Barry: COPIC building where CMS has their offices.</p> <p>No other business was addressed. Next meeting full committee meeting September 26<sup>th</sup>.</p> <p><b>PUBLIC COMMENT</b></p> <p>Marilyn: Any comments?</p> <p>None given</p> <p>Meeting adjourned at 1:55</p>		
--	--	--	--

## Attachment B

9/18/2012

CCTF Task Force Consideration

DSR Sustainability Models

Assumptions:

No public funding

Non-for-profit business model

Lowest possible price point for market

CCTF will not manage implementation of final solution

### I. Free Market

- a) Single professional entity
- b) One or more competing technical entities license data from professional entity for resale
- c) Professional and technical entity could be the same
- d) Shift economic risk to the technical vendor
- e) No price controls
- f) No requirement for trading partners to use the vendor

CO workers compensation model is a good parallel

Trading partners must purchase information from a private entity to comply with the statute

A claims administrator would have to pay for the data

A provider would only pay if monitoring compliance was a business requirement

The vendor would price based on free market principles (market size, operating costs, and margin)

Pros / Cons

No first costs for the state, no direct costs to tax payer / No vendors step up

High probability of sustainability / No price controls for buyers

Incentive to vendor for multi-state market expansion / Danger that vendor serves biggest customers interests

### II. Public utility

- a) State regulates pricing
- b) Allow multiple vendors
- c) Single professional entity
- d) One or more competing technical entities license data from professional entity for resale
- e) Professional and technical entity could be the same
- f) Additional regulation required to mandate licensing of rule set for claims processing

Trading partners statutorily must purchase information from a private entity to comply with the statute

A claims administrator would have to pay for the data

A provider would only pay if monitoring compliance was a business requirement

Pricing would be regulated

Pros / Cons

Price controls / Political problem of what entities are required to purchase

More predictable business model may attract more vendors / cost to taxpayer for management and oversight

? / Revenue center for the State if they take licensing fee to cover costs

### **III. Foundation model**

- a) Private or public (Robert Wood Johnson, CMS?) funding
- b) Piggy back on CO APCD?

Pros / Cons

Data is free / chronic anxiety about future funding and sustainability

Increased adoption /

### **IV. Cooperative**

Membership dues tiered based on annual revenues

Membership is optional but provides discount on data

Non members pay inflated price for data

Membership dues gets you access to the data

Can sell data to non members

Governance is membership and they set the dues so built in price control

Pros/Cons

Natural price control incentives / Needs right governance including disinterest parties

Equal opportunity to participate in governance by large / High reliance on effective executive director

High level of 'in kind' contribution from members / needs some seed monies (\$100K)

What if task force ends with initial data set and phase I vendor

## Attachment C

### Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
Modifier 22: Increased Procedural Services	<p><b>Description:</b> When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).</p> <p><b>Note:</b> This modifier should not be appended to an E/M service.</p>	<p>Payment modifier Doesn't override edits Documentation required – claim pended; reviewed to determine if additional payment allowed; some payers pay a flat %;</p> <p>some carriers don't consider it a clean claim if it isn't submitted; others just consider the claim as if -22 weren't submitted</p> <p style="color: red;">Modifier rules to be handled by Payment rule committee</p>	<p><b>Guideline</b></p> <ul style="list-style-type: none"> <li>• Use only when work factors requiring the physician's technical skill involve significantly more               <ul style="list-style-type: none"> <li>– Work</li> <li>– Time</li> <li>– Complexity</li> </ul> </li> <li>• For surgical and nonsurgical procedures</li> <li>• Use this modifier when the work required to provide a service is substantially greater than typically required.               <ul style="list-style-type: none"> <li>– It may be identified by adding modifier 22 to the usual procedure code</li> </ul> </li> <li>• Documentation must support the               <ul style="list-style-type: none"> <li>– Substantial additional work and reason for the addition work                   <ul style="list-style-type: none"> <li>– ie, increased intensity, time, technical difficulty of the procedure, severity of patient's condition, physical and mental effort required</li> </ul> </li> </ul> </li> <li>• May be used in these CPT code set sections               <ul style="list-style-type: none"> <li>– Anesthesia</li> <li>– Surgery</li> <li>– Radiology</li> <li>– Laboratory and pathology</li> <li>– Medicine</li> </ul> </li> </ul>	<p>Carriers continue to have authority to increase payment for unusual circumstances based on review of medical records and other documentation. Modifier 22 may be reported when services provided are greater than that usually required for the listed procedure. Documentation of the unusual circumstances must accompany the claim (eg, a copy of the operative report and a separate statement written by the physician explaining the unusual amount of work required).</p> <ul style="list-style-type: none"> <li>• Relative value units for services represent average work effort and practice expenses for a service</li> <li>• Increased or decreased payment only under unusual circumstances and after medical records and documentation review</li> <li>• Claim submission requirements               <ul style="list-style-type: none"> <li>– Concise statement about how the service differs from the usual</li> <li>– Operative report</li> </ul> </li> </ul>
Modifier 23: Unusual Anesthesia	<p><b>Description:</b> Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the</p>	<p>Payment modifier Doesn't override edits</p> <p style="color: red;">Modifier rules to be handled by Payment rule committee</p>	<p><b>Guideline</b></p> <ul style="list-style-type: none"> <li>• Used when a procedure which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia</li> <li>• Appended to the procedure code of the basic service</li> <li>• Anesthesia administration may be reported with               <ul style="list-style-type: none"> <li>– Anesthesia CPT codes</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Examples of typical anesthesia services               <ul style="list-style-type: none"> <li>– Preoperative and postoperative visits by the anesthesiologist</li> <li>– Intraoperative anesthesia care</li> <li>– Insertion of airways and intravenous lines</li> <li>– Intraoperative interpretation of perioperative laboratory tests</li> </ul> </li> </ul>

Attachment C  
 Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
	basic service.		<ul style="list-style-type: none"> <li>– Anesthesia modifier</li> <li>– Qualifying circumstance codes</li> <li>• Some payers do not accept anesthesia codes; instead require use of codes from Surgery section of CPT codebook</li> <li>• For reporting anesthesia services given by or under supervision of a physician</li> <li>• Examples of included services               <ul style="list-style-type: none"> <li>– General or regional supplementation of local anesthesia</li> <li>– Usual preoperative and postoperative visits</li> <li>– Intra-procedural anesthesia care</li> <li>– Usual monitoring services</li> </ul> </li> <li>• To report conscious sedation, see codes 99143-99150</li> <li>Reporting Anesthesia Services               <ul style="list-style-type: none"> <li>• Anesthesia services always included in CPT surgical codes                   <ul style="list-style-type: none"> <li>– Local infiltration</li> <li>– Metacarpal, metatarsal, or digital block</li> <li>– Topical anesthesia</li> </ul> </li> <li>• When to append modifier 23                   <ul style="list-style-type: none"> <li>– For a procedure that usually requires no or local anesthesia but must be done under general anesthesia</li> </ul> </li> <li>• Anesthesia services must be provided by or under physician supervision to be reported</li> </ul> </li> <li>Physician Status Modifier               <ul style="list-style-type: none"> <li>• All anesthesia services are reported by means of                   <ul style="list-style-type: none"> <li>– 5-digit anesthesia modifier procedure code (00100-01999) and</li> <li>– Physical status modifier (P1-P6), appended</li> </ul> </li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Examples of medically necessary surgical and medical services provided by anesthesiologists               <ul style="list-style-type: none"> <li>– Swan-Ganz catheter insertion (93503)</li> <li>– Central venous pressure line insertion (36555-36571)</li> <li>– Intra-arterial line insertion (36620-36625)</li> </ul> </li> <li>• To be submitted with the claim for payment               <ul style="list-style-type: none"> <li>– Surgeon's operative note, including</li> </ul> </li> <li>• Surgical time</li> <li>• Medications administered               <ul style="list-style-type: none"> <li>– Anesthesia record, including</li> </ul> </li> <li>• Anesthesia time</li> <li>• Monitors applied</li> <li>• Medications administered by anesthesia</li> <li>• Documentation of monitor readings</li> <li>• Documentation to support unusual anesthesia               <ul style="list-style-type: none"> <li>– Detailed description of the reason the case is unusual</li> <li>– Submit documentation with the claim</li> </ul> </li> </ul>

Attachment C  
 Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
			directly to all anesthesia codes • Other modifiers may be appropriate when procedural services are coded and reported in addition to the anesthesia procedure code	
Modifier 24: Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period	<b>Description:</b> The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.	Payment modifier Can override an edit --- 'G' global surgery days	<b>Guideline</b> • The E/M service must be unrelated to the surgery but provided within the global care postoperative period • Patient care has been performed by the same physician for surgery and the E/M service  • Appropriate for usage when physician provides a surgical service related to one problem, and during the postoperative period provides an E/M service unrelated to the problem requiring surgery • Used only with E/M services in the CPT codebook • Selection of the diagnosis code critical when indicating reason for E/M service	This modifier is primarily intended for use by the surgeon. In most circumstances, subsequent hospital care (99231-99233) provided by the surgeon during the same hospitalization as the surgery will be considered by the carrier to be related to the surgery. Separate payment for such visits will not be made, even if reported with modifier 24, unless documentation is submitted demonstrating that the care is unrelated to the surgery. Two exceptions to this policy are for treatment provided by immunotherapy management furnished by the transplant surgeon and critical care for a burn or trauma patient. Modifier 24 should be reported in these situations and appropriate documentation submitted with the claim.  When a visit is provided in the outpatient setting, and ICD-9_CM code indicating why the encounter is unrelated to the surgery may be sufficient documentation if it is clear the service is unrelated. If the ICD-9-CM code does not make this clear, a brief narrative explanation is required. Carriers will review all claims submitted with the 24 modifier.  • Sufficient documentation required to show that the E/M service submitted with modifier 24 was unrelated to the surgery

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
				<ul style="list-style-type: none"> <li>• Diagnosis must support that the claim is unrelated to initial procedure</li> <li>• For codes 99291 and 99292 to be paid during preoperative or postoperative period with modifier 24, submitted documentation must show that critical care was unrelated to the injury or surgery</li> <li>• Modifier 24 is not recognized for an unrelated E/M service during the postoperative period unless:               <ul style="list-style-type: none"> <li>• The care for immunotherapy management furnished by transplant surgeon</li> <li>• The care is for critical care for a burn or trauma patient</li> <li>• The documentation demonstrates that the visit occurred during a subsequent hospitalization, and the diagnosis supports the fact that it is unrelated to the original surgery</li> </ul> </li> </ul>
Modifier 25: Significant Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service	<b>Description:</b> It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A	Payment modifier Can override an edit: <ul style="list-style-type: none"> <li>• A=Unbundle (NCCI)</li> <li>• B =Mutually exclusive edit               <ul style="list-style-type: none"> <li>◦ Inc. 2 E&amp;Ms</li> </ul> </li> <li>• F=Frequency (2 E&amp;Ms)</li> <li>• G=Global Surgery days</li> </ul>	<b>Guideline</b> <ul style="list-style-type: none"> <li>• Physician may need to indicate that on the day of procedure or service was performed patient's condition required a significant, separately identifiable E/M service</li> <li>• E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided</li> <li>• Different diagnosis not required for reporting of the E/M service</li> <li>• Documentation must support the E/M level selected</li> </ul>	Modifier 25 can be used with preventive medicine codes. When a significant problem is encountered while performing a preventive medicine E/M service, requiring work to perform the key components of the E/M service, the appropriate office outpatient code also should be reported for that service with the modifier 25 appended. Modifier 25 allows separate payment for these visits without requiring documentation with the claim form. <ul style="list-style-type: none"> <li>• CMS recognizes use of modifier 25 with</li> </ul>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
	<p>significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see <b>Evaluation and Management Services Guidelines</b> for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. <b>Note:</b> This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non- E/M services, see modifier 59.</p>		<ul style="list-style-type: none"> <li>• Modifier 25 used to indicate that a significant, separately identifiable E/M service was performed by the same physician on the day of procedure</li> <li>• CPT guidelines               <ul style="list-style-type: none"> <li>– E/M service must meet the key components</li> </ul> </li> <li>• Correct use of modifier 25               <ul style="list-style-type: none"> <li>– The E/M service level needs to be supported by adequate documentation</li> <li>– E/M service can occur at same visit when a surgical procedure is performed</li> <li>– Not restricted to a particular level of E/M service</li> </ul> </li> </ul> <p><b>Supportive Phrasing for Modifier 25</b></p> <ul style="list-style-type: none"> <li>• “The patient’s condition required”               <ul style="list-style-type: none"> <li>– A key for deciding whether modifier 25 applies</li> <li>– Tells the insurance carrier of the medically necessary services on the same day that another procedure or service was performed</li> </ul> </li> <li>• “A significant, separately identifiable E/M service above and beyond” the other service provided               <ul style="list-style-type: none"> <li>– Indicates the additional service was clearly different from the other procedure/service performed</li> </ul> </li> <li>• Modifier 25 used when a significant problem is encountered while a preventive medicine service is performed, requiring additional work to perform the key components, appropriate outpatient code</li> </ul>	<p>E/M services in several codes</p> <ul style="list-style-type: none"> <li>– 99201-99499</li> <li>– 92002-92014</li> <li>– HCPCS codes G0101-G0175</li> </ul> <ul style="list-style-type: none"> <li>• Use only for provision of a significant, separately identifiable E/M service on the same day as a minor surgical procedure</li> <li>• Documentation on patient’s medical record               <ul style="list-style-type: none"> <li>– Expected to be clearly evident that the E/M service performed and billed was “above and beyond” the usual preoperative and postoperative care associated with the procedure performed on same day</li> <li>– Should indicate an important, notable, distinct correlation with signs and symptoms to make a diagnostic classification or demonstrate a distinct problem</li> </ul> </li> <li>• Questions for determining if work goes above and beyond usual pre- and postoperative work:               <ul style="list-style-type: none"> <li>– Is the work more than the usual preoperative and postoperative work?</li> <li>– Does the complaint or problem stand alone as a billable service?</li> <li>– Did the physician perform and document the key components of an E/M service for the complaint or problem?</li> <li>– Is there a different diagnosis for the significant portion of the visit? If not, was the extra work more than the usual?</li> </ul> </li> <li>• National Correct Coding Initiative (NCCI) developed by CMS to</li> </ul>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
			<p>should also be reported with modifier 25 appended</p> <ul style="list-style-type: none"> <li>• Modifier 25 allows separate payment for these visits               <ul style="list-style-type: none"> <li>• Critical care services must be unrelated to the specific anatomic injury or surgical procedure performed</li> </ul> </li> <li>• Documentation that the critical care is unrelated must be submitted to the carrier for review               <ul style="list-style-type: none"> <li>• Modifier 25 can be used for symptoms encountered during a preventive medicine visit that require substantial extra work for a problem-oriented E/M service</li> </ul> </li> <li>• Many carriers pay for only the preventive service when two E/M services (well and problematic) are billed during the same patient encounter</li> </ul>	<ul style="list-style-type: none"> <li>– Promote correct coding methods</li> <li>– Control improper coding</li> <li>• CMS will not reimburse for an E/M service in addition to the procedure when the service resulted in performance of a minor surgical procedure (with a 10-day global period) on the same date</li> </ul>
<p>Modifier 26: Professional Component</p>	<p><b>Description:</b> Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number</p>	<p>Payment modifier Can override edits:</p> <ul style="list-style-type: none"> <li>• F – Frequency edits</li> </ul> <p>Important to total/26/TC (M) editing When billed appropriately</p>	<p><b>Guideline</b></p> <ul style="list-style-type: none"> <li>• Complete service               <ul style="list-style-type: none"> <li>– The physician provides the entire service including the equipment, supplies, technical personnel, and the physician’s professional services</li> <li>– Can be divided into technical and professional components</li> </ul> </li> <li>• HCPCS level II modifier TC:               <ul style="list-style-type: none"> <li>– Identifies the technical component</li> </ul> </li> </ul> <p><b>Pathology Services for CMS</b></p> <ul style="list-style-type: none"> <li>• Billing for anatomical and surgical pathology services (both technical and professional components) must comply with:               <ul style="list-style-type: none"> <li>– The contractual arrangements between the facility and the pathologist</li> <li>– Medicare, Medicaid, and other third-party payer requirements</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Definition of a Complete service               <ul style="list-style-type: none"> <li>– The physician provides the entire service including the equipment, supplies, technical personnel, and the physician’s professional services</li> <li>– Can be divided into technical and professional components</li> </ul> </li> <li>• HCPCS level II modifier TC:               <ul style="list-style-type: none"> <li>– Identifies the technical component</li> </ul> </li> </ul>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
			<ul style="list-style-type: none"> <li>• Options for billing pathology services               <ul style="list-style-type: none"> <li>– Bill technical component only</li> <li>– Do not bill either component</li> <li>– Bill globally</li> </ul> </li> <li>• For independent laboratory billing for technical component of physician pathology services to hospital patients</li> <li>• Medicare carriers can pay the technical component of pathology services when:               <ul style="list-style-type: none"> <li>– An independent laboratory provides services to an inpatient or outpatient of a covered hospital</li> <li>– The laboratory provided the technical component of physician pathology services</li> </ul> </li> </ul>	
Modifier 32: Mandated Services	<b>Description</b> Services related to <i>mandated</i> consultation and/or related services (eg, third party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.	Considered informational (has been recommended to be used when translator services were required)	<b>Guideline</b> Include examples of parties that may request a mandated service	Modifier 32 with claims has no effect on reimbursement
Modifier 33: Preventive Services	<b>Description:</b> When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For	Payment modifier Doesn't override edit Used for benefit  Could be considered for procedure to modifier editing		

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
	separately reported services specifically identified as preventive, the modifier should not be used.			
Modifier 47: Anesthesia by Surgeon	<b>Description:</b> Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) <b>Note:</b> Modifier 47 would not be used as a modifier for the anesthesia procedures.	Informational – Not a payment modifier Doesn't override edit  Not really used by payers – Most don't allow anesthesia by surgeons	<b>Guideline</b> Local anesthesia not included: is already in the surgical package <ul style="list-style-type: none"> <li>• Modifier not for use if surgeon monitors general anesthesia provided by: intern, resident, certified RN anesthetist, anesthesiologist</li> </ul>	– Does not recognize modifier 47 – Does not cover anesthesia services provided by the surgeon or physician separately
Modifier 50: Bilateral Procedure	<b>Description:</b> Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.	Payment modifier Critical to editing – N- Bilateral procedures  <b>Refer to payment rules committee for rules about how to bill.</b>	<b>Guideline</b> The use of this modifier is only applicable to services or procedures performed on identical anatomic sites, aspects, or organs (eg, arms, legs, eyes) during the same operative session. The intent is for the modifier to be appended to the appropriate unilateral code as a single-line entry on the claim form to indicate that the procedure was performed bilaterally. When a procedure is reported with modifier 50 appended to the code, the units box on the claim form should indicate that 1 unit of service was provided because the procedure was performed bilaterally.  Although this reporting method reflects the intent of CPT coding guidelines, local third-party payer reporting guidelines may require that the code be listed twice, with modifier 50 appended to the second line entry. Third-party payers should be contacted for their respective reporting guidelines.	The bilateral modifier is used to indicated cases in which a procedure normally performed on only one side of the body. The CPT descriptors for some procedures specify that the procedure is bilateral. In such cases, the bilateral modifier is not used for increased payment. Medicare has maintained the policy of approving 150% of the global amount when the bilateral modifier is used. If additional procedures are performed on the same day as the bilateral surgery, they should be reported with modifier 51. The multiple surgery rules apply, with the highest valued procedure paid at 100% and the second through fifth procedures paid at 50%. All others beyond the fifth are paid on a by report basis.  When identical procedures are performed by two different physicians on opposite sides of the body or when bilateral procedures

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
			<p>Copyright 2007, American Medical Association</p> <p>It is not appropriate to append the modifier 50 to those CPT codes having descriptors representing a technique that may inherently involve physiology or anatomy on both the left and right side of the body. You will also note that the CPT code descriptors for these procedures/services may either:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> specifically state the procedure/service may be performed either unilaterally or bilaterally (eg, 58900, Biopsy of ovary(s)); or</li> <li><input type="checkbox"/> specify the procedure is "bilateral" (eg, 78458, Vein thrombosis images, bilateral); or,</li> <li><input type="checkbox"/> reflect multiple anatomy (eg, 73520, X-ray exam of hips).</li> </ul> <p>It is not appropriate to append modifier 50 to the radiology procedure (70000 series) codes, as there are other modifiers to designate separately identifiable procedures (eg, modifier 59). The use of specific modifiers is carrier dependent.</p>	<p>requiring two surgical teams working during the same surgical session are performed, the following rules apply : The surgery is considered cosurgery (see modifier 62) if CPT designates the procedure as bilateral (eg, 27395). The CMS payment rules allows 125% of the procedure's payment amount divided equally between two surgeons. If CPT does not designate the procedure as bilateral, CMS payment rules first calculate 150% of the payment amount for the procedure. Then the cosurgery rule is applied; split 125% of that amount between the two surgeons.</p>
<p>Modifier 51: Multiple Procedures</p>	<p><b>Description:</b> When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).</p>	<p>Informational WellPoint and Rocky Mtn -don't use to drive MPR Humana will check Amy – some large clients use it in payment process --- provider not required to use CMS – informational</p>	<p><b>Guideline</b> The modifier 51 does not apply to E/M codes, designated add-on codes, or codes designated as modifier 51 exempt (see Appendix F). The use of the modifier 51 is not restricted to operative procedures, although it is commonly used in this context. To alleviate confusion about the intent of the modifier, the definition includes language to indicate that it is not appended to add-on codes, as listed in Appendix D of the CPT codebook, E/M codes, or codes designated as modifier 51 exempt, as listed in Appendix E of the CPT codebook. To assist in determining is appropriate usage,</p>	<p>Medicare payment policy is based on the lesser of the actual charge or 100% of the payment schedule for the procedure with the highest payment, while payment for the second through fifth surgical procedures is based on the lesser of the actual charge or 50% of the payment schedule. Surgical procedures beyond the fifth are priced by carriers on a "by-report" basis. The payment adjustment rules do not apply if two or more surgeons of different specialties (eg, multiple trauma cases) each performs distinctly different surgeries on the same patient on the same day. The CMS has clarified that</p>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
	<p><b>Note:</b> This modifier should not be appended to designated “add-on” codes (see Appendix D).</p>		<p>modifier 51 has four applications, namely to identify:</p> <ul style="list-style-type: none"> <li>o Multiple medical procedures performed at the same session by the same provider;</li> <li>o Multiple, related operative procedures performed at the same session by the same provider;</li> <li>o Operative procedures performed in combination at the same session, by the same provider, whether through the same or another incision or involving the same or different anatomy; and</li> <li>o A combination of medical and operative procedures performed at the same session by the same provider.</li> </ul> <p>Modifier 51 is generally not reported with the 70000 series codes. The use of the multiple procedure modifier 51 in the 70000 series of codes is applied only to the nuclear medicine codes 78306, 78320, 78802, 78803, 78806, and 78807.</p>	<p>payment adjustment rules for multiple surgery, cosurgery, and team surgery do not apply to trauma surgery situations when multiple physicians from different specialties provide different surgical procedures, modifier 51 is used only if one of the same surgeons individually performs multiple surgeries.</p> <p>For 2011, the criteria for procedures and services to be included on the modifier 51 exempt list were clearly defined. First and foremost, all add-on codes, physical medicine and rehabilitation services, and vaccines have been excluded from being able to be coded with modifier 51. Another criterion is that the services on this list should have minimal preservice time and postservice time. Because the preservice and postservice activities of services performed together should not be replicated, only codes with minimal amounts of preservice and postservice time have been retained on this list. Additionally, services that are currently subject to multiple surgery reduction have been removed from the list to be consistent with Medicare payment policy.</p>
<p>Modifier 52: Reduced Services</p>	<p><b>Description:</b> Under certain circumstances a service or procedure is partially reduced or eliminated at the physician’s discretion. Under these circumstances the service provided can be identified by its usual procedure number and</p>	<p>Payment modifier Doesn’t override edits Most apply a percentage without review (P)</p>	<p><b>Guideline</b></p> <ul style="list-style-type: none"> <li>• Appended when service/procedure partially reduced or eliminated at the physician’s discretion</li> <li>• Not for elective cancellation of a procedure prior to anesthesia induction and/or surgical preparation in the operation suite</li> </ul>	<p>Carriers continue to have authority to increase payment for decreased payment for reduced services based on review of medical records and other documentation. Documentation of the unusual circumstances must accompany the claim (eg, a copy of the operative report and a separate statement written by the physician explaining the</p>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
	<p>the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. <b>Note:</b> For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).</p>			<p>unusual amount of work required).</p> <ul style="list-style-type: none"> <li>• For a procedure/service significantly less than usually required               <ul style="list-style-type: none"> <li>– Modifier 52 appended to procedure code</li> </ul> </li> <li>• Medicare does not recognize modifier with E/M services</li> <li>• Modifier ignored if documentation and practitioner statement about service reduction are not submitted with the claim</li> </ul>
<p>Modifier 53: Discontinued Procedure</p>	<p><b>Description:</b> Under certain circumstances, the 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 or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued</p>	<p>Payment modifier Doesn't override edits Most apply a percentage without review (P)</p>	<p><b>Guideline</b></p> <ul style="list-style-type: none"> <li>• Used to report circumstances when patients experience unexpected responses that cause procedure termination</li> <li>• Not used for reporting ASC facility services               <ul style="list-style-type: none"> <li>– See modifiers 73 and 74 for ASC facility reporting</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Valid when attached to a surgical code or medical diagnostic code when the procedure was started but had to be discontinued</li> <li>• Not valid               <ul style="list-style-type: none"> <li>– For elective cancellation of a procedure before anesthesia induction and/or surgical preparation in the operating suite</li> <li>– For outpatient hospital or ASC reporting</li> </ul> </li> <li>• Use modifier 73 or 74 for partially reduced or canceled procedure/service               <ul style="list-style-type: none"> <li>– For use with E/M service CPT codes</li> <li>– For conversion of laparoscopic or endoscopic procedure to open or when a procedure becomes more extensive</li> </ul> </li> </ul>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
	<p>procedure. <b>Note:</b> This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).</p>			
<p>Modifier 54: Surgical Care Only</p>	<p><b>Description:</b> When 1 physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.</p>	<p>Payment modifier It is important in editing – important to recognize the components of the surgical package Most apply a percentage without review (G) - Global</p>	<p><b>Guideline</b> • CPT surgery guidelines: surgical procedures include the operation and the following: – Local infiltration; metacarpal, metatarsal, or digital block; topical anesthesia – One related E/M encounter on the day before or day of procedure, after deciding to do surgery – Immediate postoperative care – Writing orders – Postanesthesia recovery evaluation</p>	<p>Used when more than one physician provides services that are part of a global surgery package.</p> <p>CMS policy allows a physician who assumes postsurgical responsibilities for a patient during the hospital stay to report subsequent hospital visits in addition to the postsurgery portion of the global fee. Physicians assuming postsurgical responsibility should report appropriate subsequent hospital care codes for the inpatient hospital care and the surgical code with modifier 55 for the postdischarge care. The surgeon reports the</p>

Attachment C  
 Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
			<ul style="list-style-type: none"> <li>– Typical postoperative follow-up care</li> <li>• CMS and many third-party payers define global physician services as the following:               <ul style="list-style-type: none"> <li>– Preoperative management</li> <li>– Surgical procedure</li> <li>– Postoperative management</li> </ul> </li> </ul>	<p>appropriate surgery code with modifier 54.</p> <p>The surgeon's payment, which includes preoperative, intraoperative, and postoperative hospital services, is based on the preoperative and intraoperative portions of the global payment. Where more than one physician bills for postoperative care, however, the postoperative percentage of the global payment is apportioned according to the number of days each physician was responsible for the patient's care.</p> <p>When postoperative recovery care is split between several physicians, they must agree on the transfer of care. The agreement may be a letter or an annotation in the discharge summary, hospital record, or ambulatory surgical center (ASC) record. They physician assuming the patient's care reports the appropriate procedure code with modifier 55 but may not report any services included in the global period until at least one service has been provided. If the surgeon relinquishes care at the time of discharge, only the date of surgery needs to be indicated when billing with modifier 54. However, if the surgeon provides care after the patient is discharged, it is also necessary to show date of surgery, date of discharge, and date on which postoperative care is relinquished to another physician.</p> <p>When a physician other than the surgeon provides occasional postoperative services</p>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
				<p>during the global period, separate payment is allowed. These services should be reported with the appropriate E/M codes. Physicians report services provided and take particular care using correct ICD-9-CM codes. Payment is not included in the global fee as long as these services are occasional and unusual and do not reflect a pattern of postoperative care. However, separate payment is not allowed if the physician is the covering physician (eg, locum tenens) or part of the same group as the surgeon who performed the procedure and provided most of the postoperative care included in the global package.</p>
<p>Modifier 55: Postoperative Management Only</p>	<p><b>Description:</b> When 1 physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.</p>	<p>Payment modifier It is important in editing – important to recognize the components of the surgical package Most apply a percentage without review (G) - Global</p>	<p><b>Guideline</b></p> <ul style="list-style-type: none"> <li>• CPT surgery guidelines: surgical procedures include the operation and the following: <ul style="list-style-type: none"> <li>– Local infiltration; metacarpal, metatarsal, or digital block; topical anesthesia</li> <li>– One related E/M encounter on the day before or day of procedure, after deciding to do surgery</li> <li>– Immediate postoperative care</li> <li>– Writing orders</li> <li>– Postanesthesia recovery evaluation</li> <li>– Typical postoperative follow-up care</li> </ul> </li> <li>• CMS and many third-party payers define global physician services as the following: <ul style="list-style-type: none"> <li>– Preoperative management</li> </ul> </li> </ul>	<p>Used when more than one physician provides services that are part of a global surgery package.</p> <p>CMS policy allows a physician who assumes postsurgical responsibilities for a patient during the hospital stay to report subsequent hospital visits in addition to the postsurgery portion of the global fee. Physicians assuming postsurgical responsibility should report appropriate subsequent hospital care codes for the inpatient hospital care and the surgical code with modifier 55 for the postdischarge care. The surgeon reports the appropriate surgery code with modifier 54.</p> <p>The surgeon’s payment, which includes preoperative, intraoperative, and postoperative hospital services, is based on the preoperative and intraoperative portions</p>

Attachment C  
 Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
			<ul style="list-style-type: none"> <li>– Surgical procedure</li> <li>– Postoperative management</li> </ul>	<p>of the global payment. Where more than one physician bills for postoperative care, however, the postoperative percentage of the global payment is apportioned according to the number of days each physician was responsible for the patient's care.</p> <p>When postoperative recovery care is split between several physicians, they must agree on the transfer of care. The agreement may be a letter or an annotation in the discharge summary, hospital record, or ambulatory surgical center (ASC) record. The physician assuming the patient's care reports the appropriate procedure code with modifier 55 but may not report any services included in the global period until at least one service has been provided. If the surgeon relinquishes care at the time of discharge, only the date of surgery needs to be indicated when billing with modifier 54. However, if the surgeon provides care after the patient is discharged, it is also necessary to show date of surgery, date of discharge, and date on which postoperative care is relinquished to another physician.</p> <p>When a physician other than the surgeon provides occasional postoperative services during the global period, separate payment is allowed. These services should be reported with the appropriate E/M codes. Physicians should be code for services provided and take particular care using correct ICD-9-CM codes. Payment is not included in the global</p>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
				fee as long as these services are occasional and unusual and do not reflect a pattern of postoperative care. However, separate payment is not allowed if the physician is the covering physician (eg, locum tenens) or part of the same group as the surgeon who performed the procedure and provided most of the postoperative care included in the global package.
Modifier 56: Preoperative Management Only	<p><b>Description:</b> When 1 physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.</p>	<p>Payment modifier It is important in editing – important to recognize the components of the surgical package Most apply a percentage without review (G) - Global</p>	<p><b>Guideline</b></p> <ul style="list-style-type: none"> <li>• CPT surgery guidelines: surgical procedures include the operation and the following: <ul style="list-style-type: none"> <li>– Local infiltration; metacarpal, metatarsal, or digital block; topical anesthesia</li> <li>– One related E/M encounter on the day before or day of procedure, after deciding to do surgery</li> <li>– Immediate postoperative care</li> <li>– Writing orders</li> <li>– Postanesthesia recovery evaluation</li> <li>– Typical postoperative follow-up care</li> </ul> </li> <li>• CMS and many third-party payers define global physician services as the following: <ul style="list-style-type: none"> <li>– Preoperative management</li> <li>– Surgical procedure</li> <li>– Postoperative management</li> </ul> </li> <li>• Guidelines state that subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date</li> </ul>	<p>Used when more than one physician provides services that are part of a global surgery package.</p> <p>CMS policy allows a physician who assumes postsurgical responsibilities for a patient during the hospital stay to report subsequent hospital visits in addition to the postsurgery portion of the global fee. Physicians assuming postsurgical responsibility should report appropriate subsequent hospital care codes for the inpatient hospital care and the surgical code with modifier 55 for the postdischarge care. The surgeon reports the appropriate surgery code with modifier 54.</p> <p>The surgeon's payment, which includes preoperative, intraoperative, and postoperative hospital services, is based on the preoperative and intraoperative portions of the global payment. Where more than one physician bills for postoperative care, however, the postoperative percentage of the global payment is apportioned according to the number of days each physician was responsible for the patient's care.</p>

Attachment C  
 Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
			<p>of the procedure (including history and physical) is included in the surgical package</p>	<p>When postoperative recovery care is split between several physicians, they must agree on the transfer of care. The agreement may be a letter or an annotation in the discharge summary, hospital record, or ambulatory surgical center (ASC) record. The physician assuming the patient's care reports the appropriate procedure code with modifier 55 but may not report any services included in the global period until at least one service has been provided. If the surgeon relinquishes care at the time of discharge, only the date of surgery needs to be indicated when billing with modifier 54. However, if the surgeon provides care after the patient is discharged, it is also necessary to show date of surgery, date of discharge, and date on which postoperative care is relinquished to another physician.</p> <p>When a physician other than the surgeon provides occasional postoperative services during the global period, separate payment is allowed. These services should be reported with the appropriate E/M codes. Physicians should report services provided and take particular care using correct ICD-9-CM codes. Payment is not included in the global fee as long as these services are occasional and unusual and do not reflect a pattern of postoperative care. However, separate payment is not allowed if the physician is the covering physician (eg, locum tenens) or part of the same group as the surgeon who</p>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
Modifier 57: Decision for Surgery	<p><b>Description:</b> An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.:</p>	Payment modifier Overrides an edit (G) – Global surgery	<p><b>Guideline</b></p> <ul style="list-style-type: none"> <li>• Used when E/M service results in initial decision to perform a surgical procedure</li> <li>• Allows separate payment for that visit at which the decision to perform the surgery was made               <ul style="list-style-type: none"> <li>– If adequate documentation is available demonstrating that the decision for surgery was made during a specific visit</li> </ul> </li> </ul>	<p>performed the procedure and provided most of the postoperative care included in the global package.</p> <p>Use of modifier 57 is limited to operations with 90-day global periods. Modifier 57 allows separate payment for the visit at which the decisions to perform the surgery was made if adequate documentation is submitted demonstrating that the decision for surgery was made during a specific visit</p> <ul style="list-style-type: none"> <li>• Append to an E/M code only when that E/M service represents the initial decision to perform a major surgical procedure</li> <li>• Do not use with E/M visits during the 0–10 day global period for minor procedures unless the visit is to decide about major surgery</li> <li>• Separate documentation not required with claim submission</li> </ul>
Modifier 58: Staged or Related Procedure or Service by the Same Physician During the Postoperative Period	<p><b>Description:</b> It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. <b>Note:</b> For treatment of a problem that</p>	Payment modifier Overrides an edit (G) – Global surgery	<p><b>Guideline</b></p> <ul style="list-style-type: none"> <li>• Revised in 2008               <ul style="list-style-type: none"> <li>– Eliminated “planned prospectively”</li> <li>– Added language “planned or anticipated during the postoperative period”</li> </ul> </li> <li>• This modifier is used to report a staged or related procedure by same physician during the postoperative period of the first procedure               <ul style="list-style-type: none"> <li>– At times, it may become necessary for a surgeon to perform one procedure and then, during the postoperative period associated with the original procedure, perform a procedure that is “staged” or related</li> </ul> </li> </ul>	<p>This modifier is not used to report the treatment of a problem that requires a return to the operating room. If a diagnostic biopsy precedes the major surgery performed on the same day or in the postoperative period of the biopsy, modifier 58 should be reported with the major surgical procedure code, for which full payment is allowed (eg, mastectomy within 10 days of a needle biopsy). Additionally, if a less extensive procedure fails and a more extensive procedure is required, the second procedure should be reported with modifier 58. If the less extensive procedure and the more</p>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
	requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.		<ul style="list-style-type: none"> <li>• Modifier 58 is appended to the procedure code for a second procedure that falls into one of three categories:               <ul style="list-style-type: none"> <li>– Planned or anticipated at the time of the original procedure (staged)</li> <li>– More extensive than the original procedure</li> <li>– Therapy following a diagnostic surgical procedure</li> </ul> </li> <li>• Use only during the global surgical period for the original procedure</li> </ul>	<p>extensive procedure are performed as staged procedures, the second procedure should be reported with modifier 58.</p> <ul style="list-style-type: none"> <li>• Not used to report treatment requiring return to the operating room</li> <li>• For diagnostic biopsy preceding major surgery on same day or in postoperative period of the biopsy, report modifier 58 with surgery code               <ul style="list-style-type: none"> <li>– Full payment allowed</li> </ul> </li> <li>• For more extensive procedure required by failure of lesser procedure, report modifier 58 with more extensive procedure</li> <li>• For less extensive and more extensive procedures performed as staged procedures, report modifier 58 with second procedure</li> </ul> <p>The National Correct Coding Initiative and Modifier 58</p> <ul style="list-style-type: none"> <li>• If a procedure is planned or anticipated, because it was more extensive than the original or because it represents therapy:               <ul style="list-style-type: none"> <li>– Modifier 58 may be appended to the second procedure during the postoperative period</li> </ul> </li> <li>• When an endoscopic procedure is performed for diagnostic purposes at the time of a therapeutic procedure, and the endoscopic procedure does not represent “scout” endoscopy:               <ul style="list-style-type: none"> <li>– Modifier 58 may be appropriately used to signify that the endoscopic procedure and the more comprehensive therapeutic procedure</li> </ul> </li> </ul>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
<p>Modifier 59: Distinct Procedural Service</p>	<p><b>Description:</b> Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. <b>Note:</b> Modifier 59 should not be appended to an E/M service. To</p>	<p>Payment modifier Overrides edits (A) Unbundle (B) Mutually exclusive (F) Frequency</p>	<p><b>Guideline</b></p> <ul style="list-style-type: none"> <li>• Used to identify procedures or services that are not normally reported together, but are appropriate under the circumstances <ul style="list-style-type: none"> <li>– Should be used only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances</li> </ul> </li> <li>• This modifier underwent revision in 2008 <ul style="list-style-type: none"> <li>– Language of “physician” in its descriptor along with language indicating that documentation must support a different session instead of “patient encounter”</li> </ul> </li> </ul> <p>Separate Procedure</p> <ul style="list-style-type: none"> <li>• Some of the procedures or services listed in the CPT nomenclature that are commonly carried out as an integral component of a total service or procedure have been identified by including the term “separate procedure”</li> <li>• Codes designated as separate procedures should not be reported in addition to the code for the total procedure or service of which it is considered an integral component</li> <li>• Examples of CPT codes with “separate procedure” in the code description <ul style="list-style-type: none"> <li>• 29870—Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)</li> <li>• 38780—Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure)</li> <li>• 44312—Revision of ileostomy; simple (release of superficial scar) (separate procedure)</li> </ul> </li> </ul>	<p>are staged or planned procedures NCCI Guidelines</p> <ul style="list-style-type: none"> <li>• Modifier 59: <ul style="list-style-type: none"> <li>– Was established for use when several procedures are performed on different anatomical sites, or at different sessions (on the same day)</li> <li>– Indicates that the procedure represents a distinct service from others reported on the same date of service</li> <li>– Is appended when distinct and separate multiple services are provided to a patient on a single date of service</li> <li>– Was developed explicitly for the purpose of identifying services not typically performed together</li> </ul> </li> <li>• Assigned modifier indicators in the National Correct Coding Initiative (NCCI) <ul style="list-style-type: none"> <li>– “0” An NCCI-associated modifier cannot be used to bypass the edit</li> <li>– “1” An NCCI-associated modifier may be used to bypass the edit if it meets the criteria under appropriate circumstances</li> <li>– “9” Edit deleted on the same date as when it became effective</li> </ul> </li> </ul> <p>CMS Guidelines for Using Modifier 59 With the Medicine Section</p> <ul style="list-style-type: none"> <li>• Chemotherapy administration codes: for administration by multiple routes <ul style="list-style-type: none"> <li>– Separate payment is allowed for chemotherapy administration by push and by infusion technique on the same day, but only one push administration is allowed on a</li> </ul> </li> </ul>

Attachment C  
 Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
	<p>report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.</p>			<p>single day            – It is recognized that combination chemotherapy is frequently provided by different routes at the same session            – Modifier 59 can be appropriately used when two different modes of chemotherapy administration are used</p> <p>CMS Guidelines for Using Modifier 59 With the Medicine Section</p> <ul style="list-style-type: none"> <li>• Fluid administration only to maintain patency of the access device, the infusion is neither diagnostic nor therapeutic.               <ul style="list-style-type: none"> <li>– Injection, infusion, or chemotherapy administration codes are not to be separately reported</li> <li>– In the case of transfusion of blood or blood products, the insertion of a peripheral intravenous line is routinely necessary and not separately reported</li> <li>– Administration of fluid in the course of transfusions to maintain line patency or between units of blood products is not to be separately reported</li> <li>– If fluid administration is medically necessary for therapeutic reasons in the course of a transfusion or chemotherapy, this could be separately reported with the modifier 59</li> </ul> </li> <li>• Biofeedback services involving electromyographic techniques               <ul style="list-style-type: none"> <li>– CPT codes 95860-95874 (electromyography) should not be reported with</li> </ul> </li> </ul>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
				<p>biofeedback services based on the use of electromyography during a biofeedback session</p> <ul style="list-style-type: none"> <li>– If an electromyogram is performed as a separate medically necessary service for diagnosis or follow-up of organic muscle dysfunction, the appropriate electromyography codes may be reported</li> <li>– Modifier 59 should be added to indicate that the service performed was a separately identifiable diagnostic service</li> <li>• Pulmonary stress testing <ul style="list-style-type: none"> <li>– For a standard exercise protocol, serial electrocardiograms, and a separate report describing a cardiac stress test (professional component), cardiac and pulmonary stress tests could be reported</li> <li>– Modifier 59 should be reported with the secondary procedure</li> </ul> </li> </ul>
<p>Modifier 62: Two Surgeons</p>	<p><b>Description:</b> When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional</p>	<p>Payment modifier Doesn't override edits Most apply percentage without review</p> <p>Tied to (K) Co-Surgeons</p>	<p><b>Guideline</b> To code a surgery that involves multiple surgeons, it is necessary to have all the operative reports of all the surgeons involved in a particular case wherein the physicians each provided distinct services, with all these services being related to one surgery. Each surgeon should report the individual procedure(s) he/she performs related to the definitive surgery indicating two surgeons have performed the work included in one total procedure, reportable with a single code. Each surgeon should report the same distinct procedural code with the modifier 62 appended. In separate operative reports, both physicians would document their level of involvement in the surgery. Each should include</p>	<p>Cosurgery may be required because of the complexity of the procedure(s), the patient's condition, or both. The additional surgeon(s) is not acting as an assistant at surgery in these circumstances. Payment is based on 125% of the global amount, which is divided equally between two surgeons. Documentation to establish medical necessity for both surgeons is required for some services.</p> <p>CMS Guidelines for Using Modifier 62 With the Radiology Section</p> <ul style="list-style-type: none"> <li>• Medicare Fee Schedule Database</li> </ul>

## Attachment C

### Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
	<p>procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. <b>Note:</b> If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.</p>		<p>a copy of the notes when reporting the service to the third-party payer. If one surgeon does not use the modifier 62, the third-party payer may assume that the physician reporting the procedure without the modifier performed the entire procedure, despite the second physician reporting the procedure with the modifier 62.</p> <p>The guidelines for use of modifier 62 denote the circumstance in which an additional surgeon for a specific surgery acts not as an assistant at surgery, but actually performs a distinct portion of the procedure in the capacity of a co-surgeon, or second primary surgeon. The use of the modifier 62 allows for greater versatility in reporting the services provided by each surgeon. From a CPT coding perspective, the use of the modifier 62 is not limited to those procedures performed by physicians of differing specialties.</p>	<p>(MFSDDB) indicators</p> <ul style="list-style-type: none"> <li>– MFSDDB indicator 1, procedures with modifier 62 paid when documentation submitted with claim</li> <li>– MFSDDB indicator 2, procedures with modifier 62 paid without documentation submitted with the claim</li> <li>– MFSDDB indicator 0 or 9, procedures may not be billed as co-surgery</li> </ul> <p>CMS and Modifier 62</p> <ul style="list-style-type: none"> <li>• Modifier 62 may be billed when two or more surgeons of same specialty perform <ul style="list-style-type: none"> <li>– Parts of one procedure</li> <li>– The same or similar procedures in separate body areas</li> <li>– Components of a related procedure or procedures generally performed by the same surgeon</li> <li>– One procedure or components of related procedures performed by two or more surgeons of different specialties</li> </ul> </li> <li>• Co-surgeon reimbursement only for procedure codes designated as eligible for modifier 62</li> <li>• For co-surgeons, the fee schedule amount applicable to the payment for each cosurgeon is 62.5% of the global surgery fee schedule amount based on the MFSDDB</li> <li>• Surgeons of different specialties each performing different procedure with specific CPT codes <ul style="list-style-type: none"> <li>• Neither co-surgery nor multiple</li> </ul> </li> </ul>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
				surgery rules apply even if the procedure(s) are performed through the same incision <ul style="list-style-type: none"> <li>• If one performs multiple procedures               <ul style="list-style-type: none"> <li>• Multiple procedure rules apply to that surgeon's services</li> </ul> </li> </ul>
Modifier 63: Procedure Performed on Infants Less Than 4 kg	<p><b>Description:</b> Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. <b>Note:</b> Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20005- 69990 code series. Modifier 63 should not be appended to any CPT codes listed in the <b>Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine</b> sections.</p>	Informational modifier  Could lead to higher percentage reimbursement – need to verify who does this	<p><b>Guideline:</b></p> <ul style="list-style-type: none"> <li>• Appended only to invasive surgical procedures</li> <li>• Reported only for neonates or infants up to a present body weight of 4 kg</li> <li>• Significant increased work intensity related to               <ul style="list-style-type: none"> <li>– Temperature control</li> <li>– Obtaining and maintaining intravenous access</li> <li>– The operation itself, which is technically more difficult with regard to maintenance of homeostasis</li> </ul> </li> <li>• Not for use with procedures for the correction of congenital abnormalities</li> <li>• Not for use with procedures that include pediatric status in descriptors</li> <li>• Examples of appropriate modifier 63 use               <ul style="list-style-type: none"> <li>– 33820 Repair of patent ductus arteriosus; by ligation</li> <li>– 44120 Enterectomy, resection of small intestine; single resection and anastomosis</li> <li>– 44140 Colectomy, partial; with anastomosis</li> <li>– 43220 Esophagoscopy, rigid or flexible; with balloon dilation</li> </ul> </li> <li>• Not for use with procedures for the correction of congenital abnormalities</li> <li>• Not for use with procedures that include pediatric status in descriptors</li> </ul>	The procedures with which modifier 63 cannot be reported are generally procedures performed on infants for the correction of congenital abnormalities and are exempt from appending the modifier 63. It is not appropriate to report the modifier 63 because the additional work that the modifier 63 is intended to represent has been previously identified as an inherent element within the procedures in this list. When appended to a procedure, the modifier 63 indicates the additional difficulty of performing a procedure, which may involve significantly increased complexity and physician work commonly associated with neonates and infants up to a body weight of 4 kg.
Modifier 66: Surgical Team	<p><b>Description:</b> Under some circumstances,</p>	Payment or Informational? Doesn't override edit	<p><b>Guideline</b></p>	Team surgery may be required because of the complexity of the procedure(s), the

Attachment C  
 Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
	<p>highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the “surgical team” concept. Such circumstances may be identified by each participating physician with the addition of modifier 66 to the basic procedure number used for reporting services.</p>	<p>Some review them and some let them go-            Some are reviewed            need to verify</p> <p>Tied to (L) Team Surgery</p>	<p>In certain CPT codes, one major procedure is listed without indicating the various components of that service that combines the work of several physicians and other specially trained personnel. If additional services are provided by any of the physicians on the surgical team, this should be indicated in a specific operative note. If one surgeon assists another surgeon with a procedure, then modifiers 80, Assistant Surgeon, 81, Minimum Assistant Surgeon, or 82, Assistant Surgeon (when qualified resident surgeon not available) may be more appropriate to report than modifier 66.</p> <p>Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of the modifier 66 to the basic procedure number used for reporting services.</p>	<p>patient's condition, or both. The additional surgeon(s) is not acting as an assistant at surgery in these circumstances. Team surgery involves a single procedure (reported as a single procedure code) that requires more than two surgeons of different specialties and is reported by each surgeon (with the same procedure code) with modifier 66. Payment amounts are determined by carrier medical directors (CMDs) on individual basis.</p> <ul style="list-style-type: none"> <li>• Section 15046 of the Medicare Carriers' Manual</li> <li>• Complex medical procedures               <ul style="list-style-type: none"> <li>– Require more than two surgeons of different specialties</li> <li>– Each physician performs a unique function requiring special skills integral to the total procedure</li> <li>– Each engaged in a level of activity different from assisting the surgeon in charge of the case</li> </ul> </li> <li>• Reimbursement for team physicians               <ul style="list-style-type: none"> <li>– Based on general reasonable charge criteria consistent with reimbursement practices in the service area</li> <li>– Amounts determined by carrier medical directors on an individual basis</li> <li>– Reported by each surgeon with same procedure code and modifier 66</li> <li>– “By-report” basis: report with chart and operative notes must be submitted with claim</li> </ul> </li> <li>• Physicians should determine procedures</li> </ul>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
				that require team approach – Complex procedures – Multiple medical conditions of one patient
Modifier 76: Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional	<b>Description:</b> It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. <b>Note:</b> This modifier should not be appended to an E/M service.	Payment modifier Overrides edits (F) Frequency (G) – Global surgery?	<b>Guideline</b> • Modifier 76 is intended to describe the same procedure or service repeated, rather than the same procedure being performed at multiple sites	• Use of modifier 76 appropriate – Procedure performed in an operating room or place equipped specifically for procedures – Medical necessity evident – Identical services performed • Examples – Follow-up X rays – Repeated electrocardiograms – Repeated coronary angiogram or coronary artery bypass
Modifier 77: Repeat Procedure by Another Physician or Other Qualified Health Care Professional	<b>Description:</b> It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. <b>Note:</b> This modifier should not be appended to an E/M service.	Payment modifier Overrides edits (F) Frequency	<b>Guideline</b> • Modifier 77 is used when a procedure is repeated by a different physician than the original physician	• CMS recognizes the use of modifier 77 – Medical necessity of repeated procedure must be evident • Modifier 77 used – When another physician repeats a procedure or service on the same day – For multiple diagnostic tests performed on the same day
Modifier 78: Unplanned Return to the Operating/Procedure	<b>Description:</b> It may be necessary to indicate that another procedure was	Payment modifier Override edits (F) Frequency	<b>Guideline</b> • Title and definition revised to distinguish this	Payment for reoperations is made only for the intraoperative and postoperative care because CMS considers these services to be

Attachment C  
 Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period	performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)	(G) Global surgery	modifier from modifier 58 <ul style="list-style-type: none"> <li>• Modifier 78 and 58 were previously used interchangeably due to inadequate distinction between them</li> <li>• Unplanned included in title indicates that Modifier 78 is reserved for unplanned/not foreseen in advance procedures</li> <li>• Title revised to indicate that Modifier 78 applies to unplanned procedure performed by the same physician rendering the initial procedure to provide consistency with the intent of modifier 78.</li> <li>• Term Operating Room expanded to include procedure room to avoid limiting this code to inpatient procedures</li> <li>• “On the same day” deleted.</li> </ul>	part of the original global surgery package. The approved amount will be set at the value of the intraoperative service the surgeon performed when an appropriate CPT code exists (eg, 32120, Thoracotomy, major; for postoperative complications). However, if not CPT code exists to describe the specific reoperation, the appropriate unlisted procedures code from the surgery section of CPT would be used. Payment in these cases is based on up to 50% of the value of the intraoperative service that was originally provided.  <ul style="list-style-type: none"> <li>• For related procedure performed on the same day or during a global period of more than 0 days</li> <li>• Used to indicate that a subsequent procedure related to the initial procedure was performed during the postoperative period of the initial procedure</li> <li>• Should be reported when complications arising from the surgery require use of the operating room</li> <li>• To be considered a complication, operating room must be required</li> <li>• When reporting a procedure with modifier 78:               <ul style="list-style-type: none"> <li>- A new global period does not begin</li> <li>- Carrier will pay the value of the intraoperative service of the code that describes the treatment of the complication(s)</li> </ul> </li> <li>• For procedure with “0” global period reported with modifier 78</li> </ul>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
				<ul style="list-style-type: none"> <li>– Carriers pay the full value for the procedure</li> <li>• If the patient is returned to the operating room after the initial operative session, but on the same day as the original surgery for one or multiple procedures:               <ul style="list-style-type: none"> <li>– Append modifier 78 to each procedure code for treatment of complication(s)</li> <li>– Multiple surgery rules do not apply</li> </ul> </li> <li>• If the patient is returned to the operating room during the postoperative period of the original surgery, but not on the same day of the original procedure, and bilateral procedures are required as a result of the complication from the original surgery:               <ul style="list-style-type: none"> <li>– Complication rules apply</li> <li>– Multiple surgery rules do not apply</li> </ul> </li> <li>• For return to operating room during postoperative period but not on the same day, and bilateral procedures required to treat complication of original surgery               <ul style="list-style-type: none"> <li>– Complication rules apply</li> <li>– Bilateral surgery rules do not apply</li> </ul> </li> </ul>
<p>Modifier 79: Unrelated Procedure or Service by the Same Physician During the Postoperative Period</p>	<p><b>Description:</b> The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)</p>	<p>Payment modifier Override edits (F) Frequency (G) Global surgery?</p>	<p><b>Guideline</b></p> <ul style="list-style-type: none"> <li>• Indicates that the operating surgeon performed a procedure on a surgical patient during the postoperative period for problems unrelated to the original surgical procedure</li> <li>• The procedure               <ul style="list-style-type: none"> <li>– Must be performed by the same physician</li> <li>– Reported by appending modifier 79 to the procedure code</li> </ul> </li> </ul>	<p>Separate payment for the unrelated procedure is allowed under these circumstances and is reported by appending modifier 79 to the procedure code. Modifier 79 is used to report, for example, an appendectomy performed during the global period of a mastectomy by the same surgeon.</p> <ul style="list-style-type: none"> <li>• Shows a second procedure by the same physician (or physician of the same specialty)</li> </ul>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
				<p>in the same surgical group) was unrelated to previous procedure for which the postoperative period has not been completed</p> <ul style="list-style-type: none"> <li>• Documentation, such as different diagnosis (ICD-9-CM), usually sufficient</li> <li>• Does not mandate a return to the operating room and not limited to surgical procedures</li> <li>• Reimbursed at 100% of the allowable amount</li> </ul>
<p>Modifier 80: Assistant Surgeon</p>	<p><b>Description:</b> Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).</p>	<p>Payment modifier Tied to (J) Assistant surgery (F) Frequency – when primary and assistant bill on same claim</p>	<p><b>Guideline</b></p> <ul style="list-style-type: none"> <li>• One physician assists another in a procedure</li> <li>• Assistant surgeon who assists a primary surgeon for entire operation or substantial portion of it               <ul style="list-style-type: none"> <li>– Reports the same surgical procedure as the operating surgeon</li> <li>– Reports the same CPT code as the operating physician, with modifier 80 appended</li> <li>– Operating surgeon does not append a modifier to the procedure reported</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• The assistant surgeon               <ul style="list-style-type: none"> <li>– Must actively assist when a physician performs a Medicare-covered surgical procedure</li> <li>– Must be involved in the actual performance of the procedure, not simply provide ancillary services</li> <li>– Would not be available to perform another surgical procedure during the same time</li> </ul> </li> <li>• Current law requires               <ul style="list-style-type: none"> <li>– Approved amount for assistant surgeons be set at the lower of the actual charge or 16% of the global surgical approved amount</li> <li>– Payment for services of assistant surgeons be made only when most recent national Medicare claims data indicate a procedure has used assistants in at least 5% of cases based on a national average percentage</li> </ul> </li> <li>• Full payment for assistant surgeon's services may be made for some procedures if documentation is provided establishing medical necessity</li> <li>• Physician not participating in the Medicare</li> </ul>

Attachment C  
 Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
				<p>program</p> <ul style="list-style-type: none"> <li>– Limiting charge is 115% of 16% of the nonparticipating fee schedule amount</li> <li>• For assistant-at-surgery with state licensure permitting this role for limited-license practitioner               <ul style="list-style-type: none"> <li>– Payment is 10.4% of the fee schedule amount for the particular surgery</li> </ul> </li> <li>• Database indicators for modifier 80 approval               <ul style="list-style-type: none"> <li>– 0 Procedure requires medical necessity documentation for Medicare payment</li> <li>– 1 Procedures not payable under Medicare Fee Schedule</li> <li>– 2 Procedure allows payment for assistant-at-surgery with modifier 80</li> <li>– 9 Assistant surgery concept does not apply</li> </ul> </li> <li>• Appropriate assistant surgeon modifier (80 or AS) must be submitted with surgical code(s) when billing for assistant-at-surgery</li> <li>• Medicare               <ul style="list-style-type: none"> <li>– Reimburses only if medical necessity is documented</li> <li>– Does not pay for an assistant when there is an assistant-at-surgery restriction</li> <li>– Reimburses for an assistant surgeon (MD, PA, NP, or CNS)</li> </ul> </li> <li>• Claims from an assistant-at-surgery               <ul style="list-style-type: none"> <li>– Subject to the same edits applied to claims from a primary surgeon or other physician providing care during the global period of a procedure</li> </ul> </li> <li>• All claims for second assistant must have</li> </ul>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
				an operative report attached – Lack of documentation to support the medical necessity for an assistant-at-surgery will cause denial of payment for the service
Modifier 81: Minimum Assistant Surgeon	<b>Description:</b> Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.	Payment modifier Tied to (J) Assistant surgery (F) Frequency – when primary and assistant bill on same claim	<b>Guideline</b> <ul style="list-style-type: none"> <li>• Assistant surgeon services required for a relatively short time</li> <li>– Second surgeon provides minimal assistance</li> <li>– Second surgeon reports the surgical procedure code with modifier 81</li> </ul>	<ul style="list-style-type: none"> <li>• Rarely recognizes modifier 81</li> <li>• For modifier 81 with procedure code with a maximum allowable payment               <ul style="list-style-type: none"> <li>– Maximum allowable payment will be no more than 13% of that in the CMS rules or the billed charge, whichever is less</li> </ul> </li> <li>• For modifier 81 with a by-report procedure               <ul style="list-style-type: none"> <li>– Maximum allowable payment for the procedure will be no more than 13% of the reasonable amount for the primary procedure</li> </ul> </li> </ul>
Modifier 82: Assistant Surgeon (When Qualified Resident Surgeon Not Available)	<b>Description:</b> The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).	Payment modifier Tied to (J) Assistant surgery (F) Frequency – when primary and assistant bill on same claim	<b>Guideline</b> <ul style="list-style-type: none"> <li>• Assistant surgeon is usually a qualified resident surgeon</li> <li>• Another surgeon may assist in surgery when qualified resident surgeon not available               <ul style="list-style-type: none"> <li>– Nonresident assistant surgeon services reported with modifier 82 appended to procedure code</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Payment not made for assistants-at-surgery services in teaching hospital with training program related to the required specialty and qualified resident available               <ul style="list-style-type: none"> <li>– Unless exceptional medical circumstances exist</li> </ul> </li> <li>• If the procedure is deemed ineligible               <ul style="list-style-type: none"> <li>– Cost cannot be passed on to the patient</li> </ul> </li> </ul> <p>Exceptional Medical Circumstances</p> <ul style="list-style-type: none"> <li>• Payment is made for the services of assistants-at-surgery in teaching hospitals in the following circumstances:               <ul style="list-style-type: none"> <li>– Emergency or life-threatening situations in which multiple traumatic injuries require immediate treatment</li> <li>– Primary surgeon has an across-the-board</li> </ul> </li> </ul>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
				<p>policy of never involving residents in perioperative care of his or her patients</p> <p>Assistant-at-Surgery Modifiers</p> <ul style="list-style-type: none"> <li>• 80: For nonteaching settings or teaching settings with resident available but not used by surgeon</li> <li>• 82: Qualified resident surgeon not available; used in teaching hospitals without approved training relevant program or no qualified resident available</li> <li>• AS: Services performed by a PA or NP</li> </ul>
Modifier 90: Reference (Outside) Laboratory	<p><b>Description:</b> When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.</p>	Informational? verify	<p><b>Guideline</b> Used by a physician or clinic when laboratory tests for a patient are performed by an outside or reference laboratory</p>	<ul style="list-style-type: none"> <li>• CMS does not recognize the use of modifier 90</li> <li>• Physicians should not bill Medicare or Medicaid recipients for laboratory work done outside the office</li> <li>• Physicians may bill insurance carriers only for laboratory testing performed in the office</li> </ul>
Modifier 91: Repeat Clinical Diagnostic Test	<p><b>Description:</b> In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. <b>Note:</b> This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with</p>	Payment Overrides edits (F) Frequency (A) Unbundle (Lab rebundling)	<p><b>Guideline</b></p> <ul style="list-style-type: none"> <li>• Modifier 91               <ul style="list-style-type: none"> <li>– Appended to laboratory code to indicate repetition of a laboratory test on same day for same patient as part of treatment</li> <li>– May not be used when other code(s) describe a series of test results</li> <li>– Would be reported only when laboratory tests are performed more than once during the same day for the same patient</li> </ul> </li> </ul> <p>Modifier 59 vs Modifier 91</p> <ul style="list-style-type: none"> <li>• Modifier 59:               <ul style="list-style-type: none"> <li>– added to report instances when distinct and separate multiple services provided to a patient on a single date of service</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• To be covered by Medicare, the repeat diagnostic laboratory test must be rendered the same day, the same test as originally rendered, and for the same patient               <ul style="list-style-type: none"> <li>– If the above criteria are fulfilled, the repeat test may be billed with modifier 91 appended</li> </ul> </li> </ul>

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
	specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.		<ul style="list-style-type: none"> <li>– used to report procedures that are distinct or independent, such as performing the same procedure for a different specimen</li> <li>• Modifier 91               <ul style="list-style-type: none"> <li>– Intended to identify a laboratory test that is performed more than once on the same day for the same patient, when it is necessary to obtain subsequent (multiple) results in the course of the treatment</li> <li>– Not intended for use when there are CPT codes available to describe the series of results</li> </ul> </li> </ul>	
Modifier 92: Alternative Laboratory Platform Testing	<p><b>Description:</b> When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701-86703, and 87389). The test does not require permanent dedicated space, hence by its design may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.</p>	Informational (P)	<p><b>Guideline</b></p> <ul style="list-style-type: none"> <li>• Modifier 92 added in 2008</li> <li>• Identifies laboratory testing using a kit or transportable instrument for single use, with disposable analytic chamber               <ul style="list-style-type: none"> <li>– Portable</li> <li>– Can be hand carried or transported to the patient for immediate testing</li> </ul> </li> <li>• Applicable only to the following               <ul style="list-style-type: none"> <li>– 86701 Antibody; HIV-1</li> <li>– 86702 Antibody; HIV-2</li> <li>– 86703 Antibody; HIV-1 and HIV-2, single assay</li> </ul> </li> </ul>	When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIC testing 86701-86703). The test does not require permanent dedicated space, hence by its design may be hand carried or transported to the vicinity of the patient for immediate testing at the site, although location of the testing is not itself determinative of the use of this modifier.
Modifier 99: Multiple	<b>Description:</b>	Informational	<b>Guideline</b>	• Modifier 99 informational only for CMS and

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
Modifiers	Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.	Some pend these for review-due to system limitations	<ul style="list-style-type: none"> <li>• Under certain circumstances two or more modifiers may be necessary to completely delineate a service               <ul style="list-style-type: none"> <li>– Modifier 99 should be added to the basic procedure</li> <li>– Other applicable modifiers may be listed as part of the description of the service</li> </ul> </li> </ul>	alerts carrier that additional modifiers are to follow
Modifier AA : ANESTH SVC PERFORMED PERSONAL		Anesthesia modifier – group with other anesthesia modifiers (P1-P5)		
Modifier AB : 12/99 END Reimburse<5 Employee		Delete – no longer valid		
Modifier AC : 12/99 END Reimburse<5 Individu		Delete – no longer valid		
Modifier AD : REIMB ANESTH > 4 PROC		Anesthesia modifier – group with other anesthesia modifiers (P1-P5)		
Modifier AE : Registered dietician		Out of scope – not dealing with provider type edits		
Modifier AF : Specialty physician		Out of scope – not dealing with provider type edits		
Modifier AG : Primary physician		Out of scope – not dealing with provider type edits		
Modifier AH : Clinical Psychologist		Out of scope – not dealing with provider type edits		
Modifier AI : Principle physician of record		Informational		
Modifier AJ : Clinical Social Worker		Out of scope – not dealing with provider type edits		
Modifier AK : Non participating physician		Out of scope – not dealing with provider type edits		
Modifier AL : NURS PRACT/TEAM NO RURAL (END)		Delete – no longer valid		

Attachment C  
 Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
Modifier AM : PHYS TEAM MEMBER SVC		Informational		
Modifier AN : PA SVC, NOT TEAM MEM (END)		Delete – no longer valid		
Modifier AP : REFRACT STATE NOT DETERMINED		Informational		
Modifier AQ : By phys in unlisted HPSA		Informational		
Modifier AR : Physician serv scarce area		Informational		
Modifier AS: PA, NP, asst at surgery		Payment modifier Tied to (J) Assistant surgery (F) Frequency – when primary and assistant bill on same claim		
Modifier AT : Acute Treatment		Informational		
Modifier AU : FURN W/ UROL, OSTOMY, TRACH SU		Informational		
Modifier AV : FURN W/ PROSTH OR ORTHOTIC		Informational		
Modifier AW : FURN W/ SURG DRESSING		Informational		
Modifier AX : FURN W/ DIALYSIS SVC		Informational		
Modifier AY : Item not for treatment of ESRD		Informational		
Modifier AZ : Dental shortage area EHR pymt		Informational		
Modifier A1 : DRESSING FOR ONE WOUND		Informational		
Modifier A2 : DRESSING FOR TWO WOUNDS		Informational		

Attachment C  
 Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
Modifier A3 : DRESSING FOR THREE WOUNDS		Informational		
Modifier A4 : DRESSING FOR FOUR WOUNDS		Informational		
Modifier A5 : DRESSING FOR FIVE WOUNDS		Informational		
Modifier A6 : DRESSING FOR SIX WOUNDS		Informational		
Modifier A7 : DRESSING FOR SEVEN WOUNDS		Informational		
Modifier A8 : DRESSING FOR EIGHT WOUNDS		Informational		
Modifier A9 : DRESSING FOR 9 OR MORE WOUNDS		Informational		
Modifier BA : FURN W/ PEN SVCS		Informational		
Modifier BL : Special acquisition of blood		Informational		
Modifier BO : ORAL FORMULA		Out of scope – derives benefit or fee schedule payment		
Modifier BP : Purchase Option Beneficiary De		Informational		
Modifier BR : Purchase Option Ben to Rent		Informational		
Modifier BU : Purchase Option Did Not Respon		Informational		
Modifier CA : PROC PAYABLE INPATIENT		Out of scope – fee schedule payment related to ASCs potentially		
Modifier CB : ESRD BENE PART A SNF-SEP PAY		Informational		
Modifier CC : Procedure Code Change		Informational		

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
Modifier CD : AMCC test for ESRD or MCP MD		Informational		
Modifier CE : Med neces AMCC tst sep reimb		Informational		
Modifier CF : AMCC tst not composite rate		Informational		
Modifier CG : Policy criteria applied		Informational		
Modifier CR : Catastrophe/Disaster Related		Informational		
Modifier CS : Related to 2010 gulf oil spill		Informational		
Modifier DA : Oral assess other than dentist		Out of scope – not dealing with provider type edits		
Modifier DD : Diag Site - Diagnostic Site		Delete – no longer valid		
Modifier DE : Diag Site - Custodial Facility		Delete – no longer valid		
Modifier DG : Diag Site - Hosp-based Dialysi		Delete – no longer valid		
Modifier DH : Diag Site - Hospital		Delete – no longer valid		
Modifier DI : Diag Site - Transfer Site		Delete – no longer valid		
Modifier DJ : Diag Site - Non-hosp-base Dial		Delete – no longer valid		
Modifier DN : Diag Site - Skilled Nursing Fa		Delete – no longer valid		
Modifier DP : Diag Site - Physician Office		Delete – no longer valid		
Modifier DR : Diag Site - Residence		Delete – no longer valid		
Modifier DU : Diag Facility to Unclassified		Delete – no longer valid		

Attachment C  
Edit Committee Modifier Review – 10/3/12

---

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
Modifier DX : Diag Site - Phys Off then Hosp		Delete – no longer valid		
Modifier EA : ESA, Anemia, Chemo-Induced		Informational		
Modifier EB : ESA, Anemia, Radio-Induced		Informational		
Modifier EC : ESA, Anemia, Non-Chemo/Radio		Informational		
Modifier ED : HCT>39% or HGB>13g>=3 Cycle		Informational		
Modifier EE : HCT>39% or HGB>13g<3 Cycle		Informational		
Modifier EG : Custod Facil - Hosp-based Dial		Delete –no longer valid		
Modifier EH : Custod Facil - Hospital		Delete –no longer valid		
Modifier EI : Custod Facil - Transfer Site		Delete –no longer valid		
Modifier EJ : SUBS CLAIMS/SOD HYALURONATE		Informational		
Modifier EM : ER Supply, Alpha-EPO Inj only		Informational		
Modifier EN : Custod Facil - Skilled Nursing		Delete –no longer valid		
Modifier EP : PART OF EPSDT PROGRAM		Informational		
Modifier ER : Custod Facil - Residence		Delete – no longer valid		
Modifier ET : EMERGENCY SERVICES		Informational		
Modifier EU : Extended Care to Unclassified		Delete – no longer valid		

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
Modifier EX : Custod Facil - PhysO then Hosp		Delete – no longer valid		
Modifier EY : NO PRACTIONER ORDER FOR SVC		Rocky – requiring that all claim lines on claim have EY –otherwise require claim split- Medicare only - should be denied WLP – will be using in future Can't create an edit to support Out of scope – benefit related and administrative related		
Modifier E1 : Upper Left, Eyelid		Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive		
Modifier E2 : Lower Left, Eyelid		Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive		
Modifier E3 : Upper Right, Eyelid		Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive		
Modifier E4 : Lower Right, Eyelid		Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive		
Modifier FA : Left Hand, Thumb		Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive		
Modifier FB : Item provided without cost		Out of scope – fee schedule related		
Modifier FC : Part Credit, Replaced Device		Out of scope – fee schedule related		
Modifier FP : Service part of Fam Plng Prog		Out of scope – benefit related		

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
Modifier F1 : Left Hand, Second Digit		Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive		
Modifier F2 : Left Hand, Third Digit		Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive		
Modifier F3 : Left Hand, Fourth Digit		Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive		
Modifier F4 : Left Hand, Fifth Digit		Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive		
Modifier F5 : Right Hand, Thumb		Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive		
Modifier F6 : Right Hand, Second Digit		Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive		
Modifier F7 : Right Hand, Third Digit		Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive		
Modifier F8 : Right Hand, Fourth Digit		Payment modifier (F) Frequency (A) Unbundling (B) Mutually Exclusive		
Modifier F9 : Right Hand, Fifth Digit		Payment modifier (F) Frequency (A) Unbundling		

Attachment C  
Edit Committee Modifier Review – 10/3/12

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
		(B) Mutually Exclusive		
Modifier GA : Waiver of Liabil Stmt on File		Out of scope – benefit related & provider contractual		
Modifier GB : NOT COV BY GLOBAL PMT DEMO		Informational		
Modifier GC : Svc Perf by Resident under Phy		Informational - potentially contractual – don't pay for residents		
Modifier GD : Unit of Service > MUE Value		Payment modifier Rocky – use to over MUE WLP – don't use? Humana – doesn't use (F) Frequency		
Modifier GE : Svc Perf by Resident w/o Phys		Informational - potentially contractual – don't pay for residents		
Modifier GF : NON-PHYS SERV C A HOSP		Out of scope – not dealing with provider type edits		
Modifier GG : Screening mammo on same day		Informational – CMS only		
Modifier GH : DX MAMMO/SCREEN MAMMO SAME DAY		Informational – CMS only		
Modifier GI : Hosp-based Dialysis--Transfer		Delete – no longer valid		
Modifier GJ : OPT OUT PRACT EMERG SVC		Informational - CMS only		
Modifier GK : Actual Item/Service Ordered		Out of scope – benefit related & provider contractual		
Modifier GL : Upgraded Item, No Charge		Informational – CMS only		
Modifier GM : MULT PATIENTS, ONE AMB TRIP		Informational		
Modifier GN : SVC BY		Out of scope – benefit related		

Attachment C  
 Edit Committee Modifier Review – 10/3/12

---

Modifier	Modifier Definition	Edit Committee Comments	CMS guidelines	Payment rule Committee Comments
SPEECH/LANG PATH				
Modifier GO : SVC BY OCC THERAPIST		Out of scope – benefit related		
Modifier GP : SVC BY PHYSICAL THERAPIST		Out of scope – benefit related		
Modifier GQ : VIA TELECOM SYSTEM				
Modifier GR : Svc by resident(per VA policy)				
Modifier GS : DOSAGE REDUCED DUE TO HCT/HGB				
Modifier GT : VIA INTERACT AUDIO/VIDEO SYST				
Modifier GU : Waiver of liability, routine				
Modifier GV : PHYS NOT PAID BY HOSPICE PROV				
Modifier GW : SVC NOT RELATE TO HOSP PT COND				
Modifier GX : Notice of liability, voluntary				
Modifier GY : Statutorily Excluded				
Modifier GZ : NOT REASONABLE OR NECESSARY		Out of scope – benefit related & provider contractual		

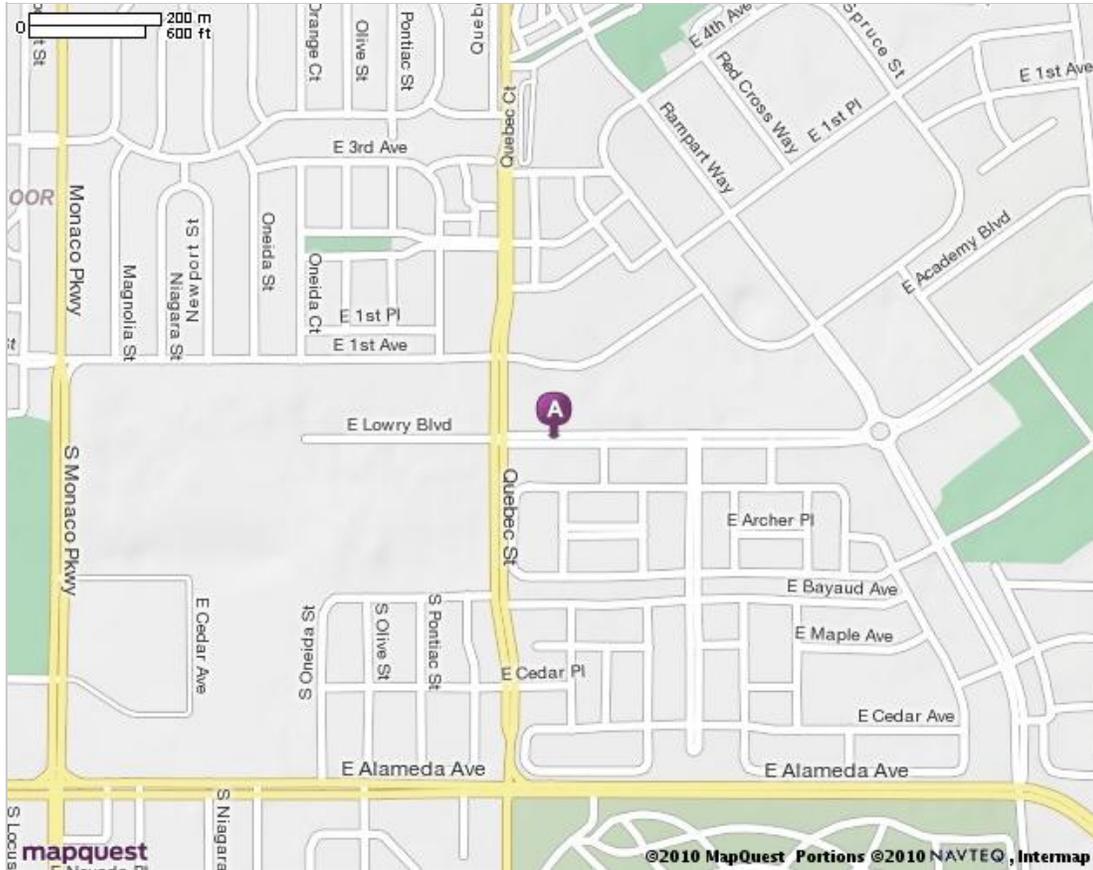


## Map of Colorado Medical Society

7351 E Lowry Blvd # 100, Denver, CO  
80230 - (720) 859-1001

### Notes

COPIC Insurance building at corner of Quebec St. and E. Lowry Blvd. Founders Board Room is on the first floor.



[All rights reserved. Use subject to License/Copyright](#) [Map Legend](#)

Directions and maps are informational only. We make no warranties on the accuracy of their content, road conditions or route usability or expeditiousness. You assume all risk of use. MapQuest and its suppliers shall not be liable to you for any loss or delay resulting from your use of MapQuest. Your use of MapQuest means you agree to our [Terms of Use](#)