PROGRAM MEMORANDUM INTERMEDIARIES

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. A-00-73 **Date OCTOBER 5, 2000**

This Program Memorandum re-issues Program Memorandum A-99-41, Change Request 937 dated September 1999. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 937

SUBJECT: Clarification of Modifier Usage in Reporting Outpatient Hospital Services

This Program Memorandum (PM) provides clarification on using modifiers in reporting outpatient hospital services. This PM answers questions that occurred after release of the following transmittals: The Medicare Intermediary Manual (HCFA Pub. 13-3), Transmittal 1729 and the Medicare Hospital Manual (HCFA Pub. 10), Transmittal 726

NOTE: The use of modifiers is an integral part of the Outpatient Hospital Prospective Payment System (PPS) payment implementation. Encourage providers to begin using modifiers now, so that any problems encountered may be adjusted prior to April 1, 2000.

General Guidelines for Modifier Use

A. Not all HCPCS codes will require modifiers.

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

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

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

  EXAMPLES:
  Code 11600 (Excision malignant lesion, trunks, arms, or legs; lesion diameter 0.5 cm. or less)

  Code 11640 (Excision malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm. or less)

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

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

B. Issues to Consider

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

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

EXAMPLE:
Cataract surgery on the right or left eye.

2. Will the modifier help to eliminate the appearance of duplicate billing?

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

3. Would a modifier help to eliminate the appearance of unbundling?

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

C. Reporting Modifiers on the UB-92 (HCFA-1450)

- Modifiers are reported on the hardcopy UB-92 (HCFA-1450) in FL 44 next to the HCPCS code. There is space for two modifiers on the hard copy form (4 of the 9 positions). On the UB-92 flat file, providers use record type 61, field numbers 6 and 7. There is space for two modifiers, one in field 6 and one in field 7.

- On the X12 837 3051.3A.01 segments SV202-03 and SV202-04 are used to report the two modifiers.

NOTE: With the upcoming claims expansion in 4/2000, up to five modifiers will fit on a line.

- The dash that is often seen preceding a modifier should never be reported.

- When it is appropriate to use a modifier, the most specific modifier should be used first. That is, when modifiers E1 through E4, FA through F9, LC, LD, RC, and TA through T9 apply, they should be used before modifiers LT, RT, or -59.

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

- Modifier -50 is used to report bilateral procedures that are performed at the same operative session as a single line item. Do **not** use modifiers RT and LT when modifier -50 applies. Do not submit two line items to report a bilateral procedure using modifier -50.

- Modifier -50 applies to any bilateral procedure performed on both sides at the same session.

- The bilateral modifier -50 is restricted to surgical procedures only (CPT codes 10040 - 69990. It is not required for radiology procedure codes or diagnostic procedure codes.

- Modifier -50 may not be used:

  - To report surgical procedures identified by their terminology as “bilateral” ,or

  - To report surgical procedures identified by their terminology as “unilateral or bilateral”.

- The unit entry to use when modifier -50 is reported is one.

- When modifier -50 is used, the reimbursement is for two procedures. If the procedure is an approved ambulatory surgery center (ASC) service, the multiple procedure rules apply. Since the procedures are in the same payment group, the ASC Pricer program calculates the payment at the full rate for one procedure, and 50 percent of the rate for the other procedure.

E. Modifiers -LT and -RT

- Modifiers -LT or -RT apply to codes which identify procedures which can be performed on paired organs, e.g., ears, eyes, nostrils, kidneys, lungs, and ovaries.

- Modifiers -LT and -RT should be used whenever a procedure is performed on only one side. Hospitals use the appropriate -RT or -LT modifier to identify which of the paired organs was operated upon.

- These modifiers are required whenever they are appropriate.

F. Use of Modifiers for Discontinued Services

1. General discussion

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

Modifier -52 was implemented for use when a procedure is terminated after a patient has been prepared for surgery (including sedation when provided) and taken to the room where the procedure is to be performed, but before the induction of anesthesia (e.g. local, regional block(s), or general anesthesia). Effective January 1, 1999, a new modifier -73 replaces modifier -52 for reporting these discontinued services.

Modifier -53 was implemented for use when a procedure is terminated after the induction of anesthesia (e.g. local, regional block(s), or general anesthesia), or after the procedure was started (incision made, intubation started, scope inserted). Effective January 1, 1999, a new modifier -74 replaces modifier -53 for reporting these discontinued services. Modifier -53 will no longer be an acceptable modifier for hospital reporting.

The elective cancellation of a procedure should not be reported.

When used to indicate discontinued procedures, modifiers -52 and -53 (and the replacement modifiers -73 and -74) are used for surgical and certain diagnostic procedures only. They are not used to indicate discontinued radiology procedures.

2. How is payment affected?

If modifier -52 (-73 effective January 1, 1999) is reported and the procedure is an approved ambulatory surgery center (ASC) service, payment will be 50 percent of the facility rate, subject to the ASC payment calculation. If modifier -53 (-74 effective January 1, 1999) is reported, there is no payment reduction. This is because the resources of the facility are consumed in essentially the same manner and the same extent as they would have been had the procedure been completed. The Medicare carriers apply these same guidelines to discontinued services performed in ambulatory surgical centers.

3. What if multiple procedures were planned and there is a termination?

When one or more of the procedures planned is completed, report the completed procedures as usual.

The other(s) that were planned, and not started, are not reported. When none of the procedures that were planned are completed, the first procedure that was planned to be done is reported with modifier -52 (-73 effective January 1, 1999) or modifier -53 (-74 effective January 1, 1999), as appropriate. The others are not reported.

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

G. Modifiers for Repeat Procedures

We have implemented the two repeat procedure modifiers for hospital use:

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

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

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

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

H. Modifiers for Radiology Services

- Modifiers -52 (Reduced Services), -59, -76, and -77, and the Level II modifiers apply to radiology services.

- Modifiers -50, -52 (for indicating a terminated service based on the guidelines in transmittal 726) and -53, and the new modifiers -73 and -74 do **not** apply to radiology services.

- When a radiology procedure is reduced, the correct reporting is to code to the extent of the procedure performed. If no code exists for what has been done, report the intended code with modifier -52 appended.

EXAMPLE: Code 71020 (Radiologic examination, chest, two views, frontal and lateral) is ordered. Only one view is performed. Report code 71010 (Radiologic examination, chest: single view, frontal). Do not report code 71020-52.

- At this time we are not reducing payment for radiology services reported with modifier - 52 (Reduced Services). Payment will still be the least of the reasonable cost, customary charge, or blended amount.

I. HCPCS Level II Modifiers

- Generally, these codes are required to add specificity to the reporting of procedures performed on eyelids, fingers, toes, and arteries.

- They may be appended to CPT codes.

- If more than one level II modifier applies, repeat the HCPCS code on another line with the appropriate level II modifier:

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

26010FA
26010F1

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

These instructions are effective 4/1/2000.

These instructions should be implemented 4/1/2000.

These instructions should be implemented within your current operating budget.

Intermediaries should direct questions concerning this PM to their HCFA regional office contacts.

The contact for this PM is Sarah Shirey. She can be reached via e-mail at s shirey @hcfa.gov.

This Program Memorandum may be discarded October 1, 2001.