

Administrative Simplification
Operational Guidelines

Simplification Area: Claims Processing

Topic: Modifier Usage for Claims Submission

Objective: Reduce claims rework and payment delay through appropriate usage of modifiers

Expected Impact: *Medical Practices:* In those cases when claims were denied or underpaid due to modifier usage related errors, billing staff spends at least 15 minutes per claim to follow-up and correct. Finding time to rework and resubmit the claim adds an additional 30 days to the payment turnaround time.

Health Plans – Staff spends at least 3 minutes per call to research and explain to a provider why a claim was denied/underpaid because of how modifiers were used.

Synopsis:

Common questions about modifier usage are answered. Health Plans spell out how to submit common modifiers whose usage is not always clear.

Background:

Modifiers should be used in conjunction with procedure codes to supply additional detail about a procedure or service that has been performed.

Modifiers provide important information, but their usage adds complexity to the billing process. Questions arise about when it is appropriate to use modifier(s), which one(s) to use, when to add them on the claim form and whether supporting documentation is required. Inappropriate use of modifiers can slow down the payment process and/or create rework of claims.

The list of possible modifiers is exhaustive. The intent of these guidelines is to answer general questions about a common set of challenging modifiers that have been identified by medical practices. For more comprehensive information about modifiers and/or how to use modifiers in coding and billing, the following links may be helpful . . .

Free websites:

- www.noridianmedicare.com/provider/pubs/med_b/news.html
- www.coding911.com
- www.cms.gov
- <http://fortress.wa.gov/dshs/maa>

Paid subscription websites:

- Code Correct - www.correctcode.com/home/
- AMA CPT Assistant - www.ama-assn.org/ama/pub/article/8183-6997.html
- Encoder Pro - www.ingenixonline.com/modules/default/default.asp?redir=1
- Part B News - www.partbnews.com/pbnweb/index.htm

General Questions and Answers about Modifiers

Q: What is a modifier?

A modifier is a 2-digit code (alpha, numeric or alpha numeric) that is to be used in conjunction with a procedure code to describe specific circumstances about the service that was provided. Use of a modifier may indicate that the procedure/service has been altered or modified by some specific circumstance, but not changed in its definition or code.

Q: Are there different types of modifiers?

There are two categories of modifiers -- CPT modifiers and HCPCS modifiers. CPT modifiers are typically, but not always, numeric. HCPCS modifiers are typically, but not always, alpha in at least the first position.

More importantly, there are two types of modifiers -- payment modifiers and information modifiers. Payment modifiers may impact reimbursement. Examples of payment modifiers are SG (ambulatory surgical center facility service), 50 (bilateral) and 80 (assistant at surgery). Payment modifiers should be placed in order of importance. As an example, if SG is relevant, it should be placed in the first position.

Information modifiers do not impact reimbursement. An example of an information modifier is LT (left).

Q: How many modifiers can be associated with a procedure on a claim line? When there are multiple modifiers for the same claim line, how should they appear on the claim form?

Most of the time, only one modifier will be associated with a procedure on a claim line.

There are a number of possible situations when multiple modifiers per claim line are appropriate. It is not practical to list all possible situations. Fortunately, there are some general rules that usually apply.

- When there are payment modifiers and information modifiers, always put the payment modifiers first. In the situation when a payment modifier and an information modifier are necessary, e.g., a procedure is done by an assistant surgeon on the left side, the payment modifier goes in the first position and the information modifier goes in the second position, e.g., 80, LT. All payment modifiers should be listed before any and all information modifiers.
- When there are multiple payment modifiers, always put the secondary surgeon related modifier first. In the situation when a bilateral procedure is performed by a provider that acted as the assistant, put the appropriate 80, 81, 82, or AS modifier before the 50 modifier, e.g., 82, 50.

Some health plan systems cannot handle multiple modifiers for a procedure on the same claim line. The following table lists how many modifiers each health plan's system can accommodate.

Modifier Usage Table

Please access the Forum's web site at www.wahealthcareforum.org/adminsimp/Claims_Process/modifiers.asp for a table of modifiers whose usage is not always clear. For each modifier, the table contains:

- A mutually accepted Description of the modifier -- along with any health plan specific comments or clarifications
- Frequently asked questions about when/how that modifier should be submitted – along with answers for each health plan

This table provides general guidelines which will apply in the majority of situations. There may be specific cases where these guidelines will not apply. **Health plans reserve the right to request documentation for any claim in order to conduct a clinical review.**

For information on how to submit supporting documentation, see 'Guidelines for Submitting Supporting Documentation' at www.wahealthcareforum.org. Click on Admin Simp Policies and Guidelines, then Claims Processing.