A Physician-Focused Guide to Applying Modifiers Correctly
March 1, 2023
Webinar FAQ Document

1. **Question** – Should modifier 59 be used with CPT code 96372 if two different medications are injected or should CPT code 96372 be coded with two units?

Answer – It would be appropriate to report CPT code 96372 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular) for each injection, with modifier 59 (Distinct procedural service) appended to the second injection. The injection code is reported per injection, even if more than one substance or drug is in the single injection.[1]

2. **Question** –Can modifiers 53 and 22 be appended to the same code? For example: 44120-22-53 (Modifier 22 for unusually complex case due to thick adhesions and modifier 53 because procedure was stopped for resuscitation and dialysis.)

Answer – There is no guideline stating that modifiers 53 (Discontinued Procedure) and 22 (Increased Procedural Services) should not be used together. If both modifiers are appropriate to fully describe the circumstances of a procedure, then it is advised to use both modifiers. Keep in mind that it may be required to submit additional documentation, such as the operative report, to avoid a denial. Documentation explaining the reason for the substantial amount of additional work or substantial time increase is critical to support the use of modifier 22.

[1] CPT Assistant, May 2010; Volume 20: Issue 5. *Medicine: Therapeutic, Prophylactic, Diagnostic Injections and Infusions, 96372 (Q&A)*

3. **Question** –In cases where the patient has a reaction during an infusion and the provider makes the decision not to give the remaining drug, can I bill that remaining drug with the JW modifier, as wasted medication?

   Answer – Yes, modifier JW (Drug amount discarded/not administered to any patient) can be appended to the code for the drug or biological if it is a single-use vial or single-use package to show that the provider administered a certain amount and discarded the rest. Documentation must include the amount of the drug that the provider discarded and should also include the reason for the discontinuation of the infusion prior to administration of the full prescribed dosage.

4. **Question** – In reference to modifier 24, on the CMS website it states that it is appropriate to use if the treatment for the underlying condition or an added course of treatment is not part of normal recovery from surgery. For example, if a patient had Botox done for migraines and had their 3 month follow up evaluation and management (E&M) visit within the 10-day global period, can the provider bill an E&M with 24 because the visit talks about all treatments for migraines and may change prescriptions for migraines? The provider mentions Botox as part of the treatment plan but also documents all treatment plans for migraines.

Answer – It may be appropriate to append modifier 24 (Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period) in this situation; however, documentation is critical in this case due to the diagnosis of migraines being the same for the procedure and the E&M visit. The documentation should state explicitly that the E&M visit is unrelated to the Botox procedure, that it is not part of the normal course of post-operative treatment, and that it is related to other treatments regarding the migraine diagnosis. The key components of an E&M service must also be met to report the E&M service. Whether this is accepted or denied will ultimately come down to the payer and their specific guidelines so you may want to check those guidelines prior to submitting the claim.

5. **Question** – Could a post-operative Z code used as secondary diagnosis, such as Z47.89 (Encounter for other orthopedic aftercare), lead to a denial of the claim when using

modifier 24 (Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period) on the E&M visit?

Answer – As long as the documentation clearly states that the E&M reported was for an unrelated problem and the key components of an E&M service are met for that problem, it should be fine to report the secondary diagnosis of Z47.89.

6. **Question** – Can modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service) be used to report an additional E/M service if it is related to the dialysis service that the patient had previously on the same day?

Answer - No, any additional E/M service related to renal failure or a previous dialysis service on the same day should not be reported separately.

7. **Question** – Can modifier 52 be used with superficial anesthesia such as numbing cream?

Answer – Yes, modifier 52 (Reduced Services) can be used with services where superficial anesthesia such as numbing cream is used. For billing purposes, anesthesia includes local, regional blocks, moderate sedation (conscious sedation), deep sedation, and general anesthesia.

8. **Question** – Would modifier 25 be appended to point of care testing during an office visit such as a urine dip or hemoglobin?

Answer – Modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service) should only be applied to significant, separately identifiable E/M services, so it would not be appropriate in this case.

9. **Question** - Can you give an example of when it's appropriate to use the XU modifier?

Answer – The XU modifier is used for an unusual non-overlapping service. The service is distinct because it does not overlap the usual components of the main service. Here are two examples of appropriate use of modifier XU:

- Use when a diagnostic procedure is performed prior to a therapeutic procedure and is clearly the basis for proceeding to the therapeutic procedure.
    - Diagnostic procedure must not have been required during the therapeutic procedure AND must clearly provide information needed to decide whether or not to proceed to therapeutic procedure.
    - Example: Patient has diagnostic angiography performed on the iliac artery prior to angioplasty of iliac artery. Angiography may be separately coded with modifier XU as long as it was done during the same date of service and resulted in decision to proceed to angioplasty.
- Use when a diagnostic procedure is performed subsequent to a therapeutic procedure only when the diagnostic procedure is not an expected or necessary follow-up.
    - Diagnostic procedure must not have been required during the therapeutic procedure AND must not be an inherent component of the therapeutic procedure.
    - Example: Patient requires a chest x-ray following chest tube insertion due to development of fever and persistent cough. Chest x-ray may be separately coded with modifier XU due to clinical indications.

Please see the following MLN article for more information on the XU modifier:
https://www.cms.gov/files/document/mln1783722-proper-use-modifiers-59-xepsu.pdf

10. **Question** - What is the appropriate way to report modifier 76 if the procedure is repeated more than once? How would you report if the procedure was completed then was repeated 3 times?

Answer – Modifier 76 (Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional) should not be reported on first procedure but should be appended to every repeat subsequent procedure. An example would be if a patient has 3 repeated electrocardiograms (ECGs). It should be reported as follows: 93000, 93000-76, 93000-76, 93000-76. Also, when modifier 76 is used, the reason for the repeated service should be entered in the narrative field in item 19 on the CMS-1500 claim form or in the designated electronic field for electronic claims.

11. **Question** - When code description states unilateral or bilateral, you said modifier 50 is not used. Will LT or RT be used when procedure was done unilateral for that code?

Answer – Yes, you may append modifier LT (Left side) or RT (Right side) to further specify which side of the body the procedure was performed on if the procedure was performed unilaterally. Also, if there is a more specific modifier appropriate for that exact anatomic site (example: TA, Left foot, great toe) it should be used instead of LT or RT.

12. **Question** - If a surgical procedure needs to be repeated days/weeks later within global period, would you use modifier 76?

Answer – Yes, modifier 76 (Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional) would be used when the exact same procedure is performed by the same physician or qualified health care professional on the same date of service or during the global postoperative period.

13. **Question** - Do they have to document additional time for modifier 22 to be added?

Answer – Substantial time increase (CMS says substantial means a 50% increase in time) during a procedure is an appropriate reason to append modifier 22 (Increased procedural services). The reason for the increased procedural time should be documented in the operative note (example: There was an obstruction in the surgical field requiring intensive dissection which caused a 50% increase in procedural time). Some Medicare Administrator Contractors (MACs) and third- party payers have their own guidelines for using this modifier so it may be helpful to review that before submitting the claim.

14. **Question** - For Modifiers 78 and 79 do the surgeries only qualify for reporting these modifiers when the same surgeon performs both procedures?

Answer – Yes, modifier 78 (Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period) and modifier 79 (Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period) should only be used when the same surgeon performs both procedures.

15. **Question** – Where can I find more information about modifiers?

Answer – Level I modifiers can be found in Appendix A of the 2023 CPT® book and level II modifiers can be found in Appendix B of the 2023 HCPCS manual. There is also a guide to modifier usage that the American Medical Association publishes called *Coding with Modifiers- A Guide to Correct CPT® and HCPCS Level II Modifier Usage.* CMS publishes guidance on modifiers through the Medicare Hospital Outpatient Prospective Payment System (OPPS) and the Medicare Physician Fee Schedule (MPFS) final rules, transmittals, and MLN matters articles which can be found on the CMS website (www.cms.gov). Some MACs and third-party payers have their own guidelines regarding modifiers which can usually be found directly on their websites.

16. **Question** - Can you provide the link to the Healthcatalyst® Insights article referenced in the presentation regarding the JZ modifier?

Answer – Here is the link. https://www.healthcatalyst.com/insights/2023-billing-coding-changes-guide-years-policy-updates

17. **Question** - Does it matter if the procedure was performed on the same day as or within the global period when using 76 modifier?

Answer – No, it doesn't matter. Modifier 76 can be used in both cases, whether the procedure was performed on the same day or at a later date within the global period.

18. **Question** - When should modifier 59 vs 91 be assigned for lab tests?

Answer – Modifier 91 (Repeat Clinical Diagnostic Laboratory Test) should only be used when it is medically necessary to repeat the same lab procedure on a single date of service to obtain multiple subsequent results. An example would be if a patient is diagnosed with hyperkalemia and a repeat potassium level is needed following treatment.

Modifier 59 (Distinct procedural service) is used to report procedures that are distinct or independent, such as performing the same procedure (that uses the same procedure code) for testing of a different specimen or a different strain. Use modifier 59 when separate results are reported for different species or strains that are described by the same CPT code.

Modifiers 91 and 59 should not be used when tests are rerun to confirm initial results, when there were issues with the original test equipment or procedure, or when multiple specimens are required to complete a single lab test (example: For a glucose tolerance test three specimens are obtained at specific intervals, and this is stated in the code description). [2]

[2] *Lab Codes with Modifiers 59 and 91 Coding Policy*. Molina Healthcare. https://www.molinahealthcare.com/providers/mi/medicaid/policies/~/media/Molina/PublicWebsite/PDF/Providers/common/Payment_Policies/PI_Coding%20Policy%204_Lab%20Codes%20with%20Modifiers%2059%20and%2091.pdf

19. **Question** - What modifier would you use if you are running the same lab, but checking for 2 different antibodies? For example, when checking for influenza A and influenza B?

Answer – In this case, modifier 59 (Distinct procedural service) should be used. Modifier 59 is used to report procedures that are distinct or independent, such as performing the same procedure (that uses the same procedure code) for testing of a different specimen or a different strain. Use modifier 59 when separate results are reported for different species or strains that are described by the same CPT code.

20. **Question** - So would the modifier 78 apply to a D&C immediately after a vaginal delivery?

Answer – Yes, modifier 78 (Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period) may be used in this circumstance as long as the D&C was unplanned and related to the vaginal delivery.

21. **Question** - Do you have any info on U6 modifiers?

Answer – Modifier U6 (Medicaid level of care 6, as defined by each state) is a Medicaid-only modifier that describes a level of care or tiered service. Modifier U6 is not recognized by Medicare. The use of this modifier relates to the amount of assistance a patient requires, the complexity of care, a type of service provided, or a particular patient situation. [3]

Medicaid is administered through each state and each state determines the description for modifiers U1-UD. Providers must check with their state

[3] *Appendix B HCPCS Level II Modifiers, Lay Descriptions, and Tips*. HCPCS Level II Expert. AAPC 2023

HealthCatalyst®

Medicaid carrier to determine the use of these modifiers.[4]

[4] *Coding with Modifiers 6th Edition-A Guide to Correct CPT and HCPCS Level II Modifier Usage*. American Medical Association.