



Introduction to Modifiers

Coding provides a common language throughout health care organizations and health care payers. The use of modifiers is an important part of coding and billing for health care services. Due to changes in rules and regulations with Medicare and various commercial payers, modifier usage is increasing yearly.

Correct modifier use is also an important part of avoiding fraud and abuse or non-compliance issues. One of the top billing errors determined by federal, state and private payers involves the incorrect use of modifiers. This is true within the four-state jurisdiction of WPS Medicare.

There are times when the coding and ***modifier information issued by the Centers for Medicare & Medicaid Services (CMS) differs from the American Medical Association's (AMA) coding advice regarding the use of modifiers.*** A clear understanding of Medicare's rules and regulations is necessary in order to assign the modifier correctly. This is particularly true for modifiers 22, 25, 50, 51, 59, 76 and 78. Please take careful note of the Medicare usage guidance provided in this manual.

MODIFIERS

Procedure codes may be modified under certain circumstances to more accurately represent the service or item rendered. For this purpose, modifiers are used to add information or change the description of service in order to improve accuracy or specificity. The documentation of the service provided must support the use of the modifier. There are two levels of modifiers, one for each level of HCPCS codes. This manual contains a partial list of the most commonly used codes. Please refer to your CPT and HCPCS Coding Manuals for the complete list.

⇒ **Level I (CPT) Modifiers**

Level I modifiers are two numeric digits. They are updated annually by the American Medical Association (AMA). *The explanations that follow some modifiers, while close to the AMA's explanations, are the carrier's explanations, not those of the AMA.*

⇒ **Level II (CMS) Modifiers**

Level II modifiers are two digits (AA through VP). They are recognized nationally and are updated annually by CMS.

INAPPROPRIATE MODIFIER USAGE

The system used by Part B carriers to process claims is called the Multi-Carrier System or MCS. The MCS system will deny claims as "unprocessable" for inappropriate modifier use. If the use of a procedure code/modifier combination is inappropriate, you will need to make the necessary corrections and resubmit the claim.



Important Review Facts

- Adding modifiers 24, 25, 26, 58, 59, 76, 78, or 79 to a denied service continues to be one of the top reasons for requesting a review.
- Remember that two different ICD-9-CM codes alone does not justify adding modifier 25.
- Calling to add a modifier just because the service was denied is not appropriate.
- Having front-end edits in your individual claim processing system can eliminate a delay in payment for you and unnecessary follow-up work for both WPS Medicare and your offices.
- Be prepared before calling in for a review. We have experienced providers calling and asking to add a modifier. Then when that modifier did not get the claim paid, they want to try another one. This is inappropriate.

Important Documentation Facts

- It may be necessary to use the phrase “additional documentation available upon request” in the narrative field of your claim in order to support the modifier used.
- It is necessary to indicate you have documentation with modifier 22, critical care, and co-surgery modifiers for the same specialty.
- When documentation is requested because of modifier usage, the number one reason for denial is because the documentation is not returned in a timely manner.

Important Miscellaneous Facts

- It is only appropriate to report modifiers 24, 25 and 57 on evaluation and management procedure codes.
- Never report modifier 76 on a surgical procedure code.
- When it is necessary to report the following payment modifiers with another modifier, the payment modifier must be reported in the first modifier field: TC, 26, 52, 53, AA, AD, QK, QW, QY and QZ.
- Report modifiers 54 and 55 on the surgery code only.

Anesthesia Modifiers

Information related to anesthesia modifiers is located in the WPS Medicare Policy “Anesthesia Services: AN-001”

Anesthesia Modifiers:

AA AD QK
QW QX QY QZ