North Carolina Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance

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Attention: **Ambulatory Surgical Centers, Certified Registered Nurse Anesthetists, Birthing Centers, Chiropractors, Independent Labs, Independent Nurse Midwives, Independent Nurse Practitioners, Optometrists, Physician Services in Federally Qualified Health Centers, Physician Services in Rural Health Clinics, Physician Specialties (All), Planned Parenthood (non M.D.), Podiatrists, Portable X-rays**

MODIFIERS

North Carolina Medicaid

Modifier Special Bulletin

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Attention:

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Birthing Centers
Certified Registered Nurse Anesthetists
Chiropractors
Independent Labs
Independent Nurse Midwives
Independent Nurse Practitioners
Multi-specialty Clinics
Optometrists
Physician Services in Federally Qualified Health Centers
Physician Services in Rural Health Clinics
Physician Specialties (all)
Planned Parenthood (non M.D.)
Podiatrists
Portable X-Ray

Purpose

Effective with claims received beginning June 25, 1999, the Division of Medical Assistance (DMA) and it's fiscal agent, EDS, will process Medicaid claims using modifiers. Modifiers are two-digit identifiers billed with the procedure code to convey specific information regarding the procedure or service to which it is appended. Using modifiers when processing physician and practitioner claims enables Medicaid to adopt many of Medicare's policies, and allow providers to bill more uniformly between carriers.

Guidelines

Providers will continue to submit the existing HCFA-1500 claim format to the Medicaid program via paper or electronic submission. Instead of using type of treatment codes, providers are required to bill utilizing modifiers, up to three per detail, to denote specific information regarding the services rendered. A modifier allows a provider to indicate that a service rendered to a patient has been altered by some special circumstance(s) while the code description remains the same. If no special circumstances exist and further description of the service rendered is not needed, the code should be billed without a modifier. Using appropriate modifiers will be required, but not all circumstances will need a qualifying modifier.

Individual modifier sections may reference applicable procedure code lists. Providers should be aware that not all procedure codes identified are approved for all provider types. The limitation of billing specific procedure codes according to provider types will remain under these new processing guidelines.

Documentation Requirements

Medical records should not be submitted with Medicaid claims unless specifically requested. However, documentation supporting billed services must be maintained in the patient's medical records. The North Carolina Administrative Code at 10 NCAC requires Medicaid providers to retain patient records for a minimum of five years from the date of service. Providers must make this information available to DMA or its agents upon request.

Presentation of Information in Special Bulletin

This Modifier Special Bulletin is being distributed to the aforementioned Medicaid-enrolled provider types. It is sectioned into each modifier or related group of modifiers Medicaid has selected to implement. Each section will offer a general definition of the modifier, applicable providers, billing guidelines, and specific coding information when applicable. It will also include pertinent policy changes. This manual does not include general Medicaid policies and procedures or other applicable state or federal laws, rules, and regulations currently in practice. This document serves as a supplement to other billing and reference materials.

Global Surgery Policy

Introduction

The global surgical package is an all-inclusive package associated with a procedure. The global surgery package for a major procedure includes a preoperative period (one day prior to the date of surgery), intraoperative care (the day of the surgery), and a postoperative period (a predetermined amount of time following the procedure based on the complexity of the procedure). The postoperative period begins the day after the surgery.

The global surgery package for a minor procedure includes the day of surgery and a pre-determined postoperative period beginning the day after surgery.

Surgical procedures are classified as major procedures or minor procedures.

Major Procedures

The major global surgical policy reimburses the physician performing the surgery one fee for the following services related to the surgery:

- Preoperative visits
- Intraoperative services
- Complications following surgery
- Postoperative visits
- Postsurgical pain management by the surgeon
- Supplies and miscellaneous services

When one or more physicians perform portions of these services, a modifier must be used to identify the circumstance in order to receive reimbursement during the global period. (See Billing Guidelines.)

Major procedures are assigned a 60 or 90 day follow up care period. For most major procedures the global surgery period includes one day preoperative, one day intraoperative, and 90 days postoperative, to equal a total of 92 days.

Minor Procedures

Minor surgical procedures are assigned either a zero day follow up care period or a ten day follow up care period. If the procedure is assigned ten follow up care days, the total global surgery period includes one day intraoperative and ten days postoperative, to equal a total of 11 days. There is no preoperative care day assigned to minor procedures.

Billing Guidelines

Medicaid adopted the following modifiers to further identify services or procedures furnished during a global period that are not normally a part of the global surgery fee. Please reference individual modifier sections for complete information.

24	54	57	78
25	55	58	79

Modifier 54: Surgical Care Only

Applicable Providers

- Physicians, all specialties
- Podiatrists
- Multi-specialty Clinics
- Nurse Practitioners
- Nurse Midwives

General Information

Modifier 54 denotes "surgical care only". Modifiers 54 and 55 allow a provider other than the surgeon to receive reimbursement for the follow-up care related to a major or minor surgery. Modifier 54 is appended to a surgical procedure code if the surgeon agrees to relinquish the postoperative management to another provider.

Policy

Under Medicaid's global surgical policy, a single fee is paid for all necessary related services normally furnished the day before the procedure, the day of the procedure, (including the procedure), and a specific predetermined period of time following the procedure. The postoperative period of time is determined by the complexity of the procedure. The reimbursement allowed amount for the global package includes all services necessary to prepare for and recover from the surgery.

Medicaid reimburses for the surgical portion only of the surgical package when the patient's follow up care is transferred to another provider. The surgeon identifies his intent of transferring the follow up care of the patient by appending modifier 54 to the surgical procedure code. Preoperative services are included in the reimbursement for the surgery when billed with modifier 54. Placing modifier 54 to a surgical code serves as notification of the transfer of the patient's care, therefore, documentation of this agreement does not have to be submitted on the claim.

Reimbursement for codes billed with modifier 54 is based on the Federal Register Percentage Table. This table shows the percentage of the total global reimbursement amount that is allocated to the preoperative care, the surgical care, and the postoperative care. Reimbursement for global surgical care that is rendered by more than one physician, regardless of how many, will not exceed the amount allowable if all services were rendered by a single physician.

Billing

- When a provider performs surgery and all the postoperative services related to the surgery, the provider bills the surgery code without modifier 54 or 55.

- When one provider performs surgery and another assumes all related follow up care, the surgeon bills the surgery code with modifier 54. The provider performing the postoperative care bills the surgery code with modifier 55. The date of service on each claim must be the date of surgery.

- If the provider that performs surgery also performs a portion of the follow-up, he must bill the surgical procedure code on one detail with modifier 54, and a second detail with the same date of service and same surgical procedure code with modifier 55. The dates the provider was responsible for postoperative care **must** be noted in the new FROM and TO date fields on the HCFA 1500 in block 16 or in the designated field for tape or ECS formats. For example: a neurosurgeon performs a craniotomy (procedure code 61312) on 02-03-99. The postoperative plan for the patient is that the surgeon will oversee postoperative care for the 5 days while the patient remains in the hospital, then relinquish postoperative care to a neurologist.
  - The surgeon must bill code 61312-54 with date of service 02-03-99 on one detail.
  - On a separate detail he must bill 61312-55, also with date of service 02-03-99. (Individual dates of service for follow up care are not billed.)
  - In the new date field, (block 16 on the paper HCFA 1500 form), the surgeon must place 02-04-99 in the FROM date and 02-08-99 in the TO date. Postoperative management starts the day following surgery.

- If multiple surgical procedures are performed, append modifier 54 to each surgery if the physician that performs the procedures plans to have another physician perform the postoperative care for each surgery. Multiple surgery rules for modifier 51 also apply.

- Modifier 54 must be appended to the surgery code, never to an evaluation and management code.

- Reimbursement for preoperative care is included in payment for surgery. At this time, Medicaid is not recognizing modifier 56 to denote a provider other than the surgeon providing preoperative care. Reimbursement is determined through the payment percentage as defined by the Federal Register Percentage Table.

- Refer to the chart entitled “Surgical and Postoperative Billing Scenarios” for additional billing guidelines.

Surgical and Postoperative Billing Scenarios		
Services Rendered	**By**	**How to Bill**
Surgery, preoperative care and all postoperative care	Physician #1	Bill the surgical procedure code, **no** modifier 54 or 55 Date of service must be the date of surgery
Surgery and preoperative only	Physician #1	Bill the surgical procedure code with modifier 54 Date of service must be the date of surgery
Postoperative care only	Physician #2 (or more)	Bill the same surgical procedure, same date of service, and same place of service as the surgeon, **with** modifier 55 Date of service on the detail must be the date of surgery The dates that physician # 2 performed postoperative care must be noted in field 16 of the HCFA 1500 form
Surgery, preoperative care and initial postoperative care	Physician #1	First detail: Bill the surgical procedure code **with** modifier 54 Second detail: Bill the same procedure code, same date of service, and same place of service as the first detail, **with** modifier 55 The dates that the surgeon was responsible for postoperative care must be noted in field 16 of the HCFA 1500 form
Remaining Postoperative care	Physician #2 (or more)	Bill the same surgical procedure code as physician # 1, **with** modifier 55 Date of service must be the date of surgery The dates that the physician was responsible for postoperative care must be noted in field 16 of the HCFA 1500 form

Coding Guidelines

Refer to the April, 1999 Medicaid Bulletin for a list of major and minor surgical procedures.

Modifier 55: Postoperative Management Only

Applicable Providers

- Physicians, all specialties
- Podiatrists
- Optometrists
- Multi-specialty Clinics
- Nurse Practitioners
- Nurse Midwives

General Information

Modifier 55 denotes "Postoperative management" only. Modifier 55 allows a provider other than the surgeon to receive reimbursement for the follow-up care related to a major or minor surgery. The provider that performs the surgery designates with modifier 54 that he/she is transferring either all or a portion of the postoperative management to another provider. Modifier 55 must be appended to the surgical procedure code billed by the provider rendering postoperative care. Postoperative management of a single procedure can be rendered by one or more providers. When more than one provider bills for postoperative care, reimbursement will be based on the number of days each provider was responsible for the patient's care.

Even though modifier 55 is appended to a **surgical** procedure code, the services it represents are postoperative visits, supplies and miscellaneous services such as dressing changes, suture removal, etc.

Policy

Under Medicaid's global surgical policy, a single fee is paid for all necessary related services normally furnished the day before the procedure, the day of the procedure (including the procedure), and a specific predetermined period of time following the procedure. The postoperative period of time is determined by the complexity of the procedure. The reimbursement allowed amount for the global package includes all services necessary to prepare for and recover from the surgery.

Medicaid will allow a provider other than the physician performing the surgery to be reimbursed for postoperative management of a patient if the surgeon has relinquished the follow up care to that provider by billing with modifier 54. The provider rendering postoperative management care identifies these services by appending modifier 55 to the surgical procedure code. The provider must also specify the days he was responsible for care in the FROM and TO dates in **block 16** on the HCFA-1500 claim. The detail date of service must be the date of the surgery.

Reimbursement for codes billed with modifier 55 is based on the Federal Register Percentage Table. This table shows the percentage of the total global reimbursement amount that is allocated to the preoperative care, the surgical care, and the postoperative care. Reimbursement for global surgical care rendered by more than one physician, regardless of the number of physicians, cannot exceed the amount allowable if all services were rendered by one physician.

Billing

- The physician assuming postoperative care cannot bill until he has provided at least one postoperative service. At that time he must bill the **surgical code** with the surgery date as the detail date of service and append modifier 55. The dates the provider is responsible for postoperative management must be in block 16 of the HCFA-1500. Dates in block 16 must not exceed the assigned number of follow up days for each procedure code.

- Only one unit of service is billed on the detail with modifier 55 regardless of the number of postoperative visits or services rendered. Individual dates on which the provider rendered postoperative visits or services are not itemized on the claim.

- The provider performing the surgery and a portion of the postoperative care must bill the surgical procedure code on one detail with modifier 54, and a second detail with the same date of service and same surgical procedure code with modifier 55. The dates the provider was responsible for postoperative care **must** be noted in the new FROM and TO date field in block 16 on the HCFA 1500 claim form. (Refer to modifier 54.)

- A provider rendering postoperative management for multiple surgeries performed on the **same day** must bill for each surgery with modifier 55. The provider must also follow multiple surgery guidelines by appending modifier 51. Postoperative management for surgeries on **different dates of service** must have each date of service billed on a separate claim form.

- A transfer agreement for postoperative care rendered by another physician must be documented in the medical record. . Documentation can take the form of a notation in the hospital or ambulatory surgical center record or discharge summary. When a transfer of care does not actually occur but another physician of a different specialty provides services without assuming the follow-up care, the surgeon does not append any modifier to the surgery code. The physician providing the service bills the appropriate level of Evaluation and Management code.

- Refer to the chart entitled “Surgical and Postoperative Billing Scenarios” in modifier 54 for additional billing guidelines.

Coding Guidelines

Refer to the April, 1999 Medicaid Bulletin for a list of major and minor surgical procedures.

Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

Applicable Providers

- Physicians, all specialties
- Podiatrists
- CRNA
- Multi-specialty Clinics

General Information

Evaluation and management (E/M) services on the same day as surgery are considered included in the service of surgery and are not routinely allowed separate reimbursement. A physician may need to indicate that the patient's condition required a separate procedure on the day a minor procedure was performed. Modifier 25 appended to an E/M procedure code denotes that the service was a significant, separately identifiable service performed by the same physician on the same day as the minor procedure, and should be reimbursed separately.

Policy

Modifier 25 is used only when the significant separately identifiable service is rendered on the same day as a **minor** procedure. (A minor procedure has zero or ten postoperative days.) The patient's condition must justify that the service provided is significant and beyond the usual surgical preoperative and postoperative care associated with the procedure that was performed.

Billing

- Modifier 25 is appended to E/M codes rendered on the same day as a minor surgical procedure.
- Modifier 25 is not billed with E/M codes denoting unrelated subsequent hospital visits or follow up inpatient consultation rendered on the same day as inpatient dialysis (90935-90947) or inpatient ventilation management (94656-94662). The relative value units for these codes include all payment for subsequent hospital visits and follow up consultations, even if they are unrelated to the dialysis or ventilator management.

Coding Guidelines

Modifier 25 can be used only with the following codes:

92012	99214	99220	99232	99238	99291	99347
92014	99215	99221	99233	99239	99292	99348
99211	99217	99222	99234	99261	99331	99349
99212	99218	99223	99235	99262	99332	99350
99213	99219	99231	99236	99263	99333	99433

If an E/M code does not appear on this list, modifier 25 is not required for separate reimbursement. Modifier 25 is not used to identify separate services for anesthesia.

Refer to the April, 1999 Medicaid Bulletin for a list of minor surgical procedures.

Modifier 57: Decision for Surgery (Made Within the Global Surgical Period)

Applicable Providers

- Physicians, all specialties
- Podiatrists
- CRNA
- Multi-specialty Clinics

General Information

Modifier 57 appended to an Evaluation and Management (E/M) code denotes that the visit resulted in the decision for a major surgery.

Policy

Select E/M services provided on the day of or the day prior to major procedures are considered included in the service for surgery and are not reimbursed separately. However, separate reimbursement can be made if modifier 57 is appended to the appropriate level of the E/M service to indicate that the initial decision to perform a **major** surgery was made during the visit on the day before or the day of the surgery. (A major surgery has a 60 or 90 day postoperative period.)

Billing

- Modifier 57 is appended to an E/M service when the visit results in the decision to perform major surgery, and occurs the day before or the day of surgery. Both the E/M service and the surgery must be rendered by the same provider.
- Modifier 57 cannot be billed if the E/M service was provided on the day of or the day before a procedure with zero or ten postoperative days.
- Modifier 57 cannot be billed on E/M services rendered on two consecutive days for the same patient.
- Modifier 57 is not be appended to the surgical procedure code.

Coding Guidelines

Modifier 57 can be used with the following codes:

92012	99214	99220	99232	99238	99291	99347
92014	99215	99221	99233	99239	99292	99348
99211	99217	99222	99234	99261	99331	99349
99212	99218	99223	99235	99262	99332	99350
99213	99219	99231	99236	99263	99333	99433

Refer to the April, 1999 Medicaid Bulletin for a list of major surgical procedures.

Modifier 24: Unrelated E/M Service by the Same Physician During a Postoperative Period

Applicable Providers

- Physicians, all specialties
- Multi-specialty clinics
- Podiatrists
- CRNA
- Optometrists
- Chiropractor
- Independent Lab
- Planned Parenthood
- Nurse Practitioner
- Nurse Midwives
- Portable X-Ray

General Information

Modifier 24 indicates that certain Evaluation and Management (E/M) services performed during the postoperative period of a major or minor surgery by the **same** provider who performed the procedure or by the provider responsible for the postoperative care of the patient are unrelated to the original procedure performed. This must be supported by a diagnosis that is unrelated to the original procedure. The postoperative period begins the day following surgery.

Policy

Evaluation and management codes are normally considered part of the global package. If appended with modifier 24, Medicaid will reimburse an unrelated E/M service rendered during the **postoperative period** of a major or minor procedure to the same provider that performed the original procedure or to the provider responsible for postoperative care. Appending modifier 24 denotes that the service was unrelated to the original surgery. In addition, a diagnosis unrelated to the original surgery **must** be billed as the primary diagnosis. Medicaid will not require medical records be submitted with the claim to support the diagnosis, however, there must be evidence in the medical record to substantiate the unrelated condition.

Separate reimbursement will be allowed without appending modifier 24 if an **unrelated** E/M service is rendered during the postoperative period by a different provider with a **different specialty** than the provider that performed the original procedure. Separate reimbursement will also be allowed without appending modifier 24 if a service **related** to the original surgery but not part of the postoperative services is rendered by a different provider with a **different specialty** than the provider that performed the original procedure. An example of this is a consultation with a radiologist or oncologist to determine the course of treatment following surgery.

Even though modifier 24 is defined as an unrelated E/M service by the same provider, Medicaid is allowing modifier 24 to be used by different providers with the **same specialty** as the surgeon if that provider renders an E/M service for an unrelated diagnosis during the postoperative period. Failure to bill modifier 24 and the unrelated diagnosis will result in denial. Following this procedure allows providers to avoid receiving a denial and the necessity of requesting an adjustment for reimbursement for unrelated procedures.

Medicaid does not include critical care, prolonged services, emergency care services, neonatal intensive care services, nursing facility services, or home services in its global postoperative package. These E/M services can be reimbursed separately if billed within the postoperative period. Appending modifier 24 is accepted but not required.

Billing

- The surgeon and the provider rendering postoperative management of the patient must bill for unrelated E/M services rendered within the postoperative period with modifier 24 and a diagnosis that is unrelated to the original procedure.

- Appending modifier 24 to an E/M code to denote an unrelated procedure must be supported by a diagnosis code that clearly identifies the reason why it is unrelated to the original procedure. Using modifier 24 alone will not support reimbursement, but modifier 24 plus an unrelated diagnosis will.

- The diagnosis code that best describes the patient's diagnosis, condition, problem or other reason for the visit or encounter must be placed as the **first** diagnosis occurrence. Codes for other diagnoses, such as chronic conditions, may be billed as secondary or additional diagnoses. Refer to the March, 1999 Medicaid Bulletin for diagnosis coding guidelines.

- When billing for a new admission within the postoperative period, the same billing rules apply. If the admission E/M service is unrelated to the original procedure, the service must be billed with modifier 24 appended to the E/M code and a diagnosis code proving the service is unrelated must be billed as the primary diagnosis. If the new admission is due to a complication of the original procedure, it is considered related and will not be reimbursed separately.

- Global periods are defined for major and minor procedures:

Major procedures:	**Minor procedures:**
1 day preoperative period	1 day of surgery
1 day of surgery	+10 days following surgery
+90 days following surgery*	11 days total global period
92 days total global period	

*Obstetrical codes are assigned 60 days following surgery.

Coding Guidelines

- Modifier 24 can be appended to evaluation and management codes (range 99201 - 99499) and health screening (code W8001) to denote the service is unrelated.

- For a list of major and minor procedure codes, refer to the April, 1999 Medicaid Bulletin.

Modifier 58: Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

Applicable Providers

- Physicians, all specialties
- Optometrists
- Podiatrists
- CRNA
- Multi-specialty Clinics
- Planned Parenthood
- Nurse Practitioners
- Nurse Midwives

General Information

Modifier 58 reports a related or staged procedure or service was performed by the same provider during the postoperative period of the original procedure. It is used with major or minor surgical procedures only. If the related procedure has postoperative days, a new follow-up period will start with the new procedure.

Policy

Procedures billed by the same provider within the postoperative period of an original procedure are considered part of the global surgical package. Modifiers that indicate related or unrelated procedures during the postoperative period are 58, 78 and 79. In order to receive reimbursement for related or unrelated procedures during the postoperative period, modifier 58, 78 or 79 must be appended to the procedure code. Procedures are considered outside of the global package if they are:

1. a related or staged procedure (modifier 58),
2. a procedure requiring a return trip to the operating room during the postoperative period (modifier 78), or
3. an unrelated procedure during the postoperative period (modifier 79).

If one of these modifiers is not appended, the service will be denied as included as part of the global period.

Modifier 58 is used only if the procedure is billed by the same provider within the postoperative period of the original procedure, and is used by the operating surgeon only.

Billing

- Modifier 58 indicates the performance of a procedure or service during a postoperative period is:
  1) "staged" or planned prospectively at the time of the original (i.e., a surgical procedure done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure),
  2) more extensive than the original procedure,
  3) for therapy following a diagnostic surgical procedure, or
  4) an other related procedure.

Billing examples

Staged or prospectively planned procedure: Sternal debridement (21627) is performed for mediastinitis, and it is noted that a muscle flap repair (15734) is needed subsequent to the sternal debridement to properly close the defect. Procedure code 15734 with modifier 58 appended should be submitted since the muscle flap repair was planned at the time of the initial surgery (staged).

More extensive than the original procedure: A surgeon treats a diabetic patient with advanced circulatory problems. The initial surgery results in three gangrenous toes being amputated from the patient's left foot, and is billed *Amputation, toe; metatarsophalangeal joint* 28820-T1, 28820-51-T2, 28820-51-T3. During the postoperative period it becomes necessary to amputate a portion of the patient's left foot. Procedure code 28805, *Amputation, foot; transmetatarsal,* with modifier 58 appended should be submitted since the partial amputation of the left foot is more extensive than the original procedure.

For therapy following a diagnostic surgical procedure: An incisional prostate biopsy (55705) is done, and the specimen returns from the pathologist as "positive CA of the prostate". Within the 10-day follow up period of the prostate biopsy, a radical perineal prostatectomy with bilateral pelvic lymphadenectomy is performed. Procedure code 55815 with modifier 58 appended should be submitted since the therapy followed a diagnostic surgical procedure.

- Modifier 58 is appended to major and minor surgical procedures only. It is not used on evaluation and management (E/M) codes.

- Modifier 58 is not used with procedure codes that are described as "one or more services". These procedures are considered multiple sessions or are otherwise defined as including multiple services**.** In these instances, the code should be reported one time for the entire treatment period, regardless of the number of services required to complete the procedure. Reimbursement for these "multiple session" codes is based on the sum of the total procedures. Therefore, separate reimbursement will not be made for each segment of the procedure, even if it is for more than one service. (Refer to Coding Guidelines.)

- If more than one physician is involved in a staged procedure, each physician must submit a claim for the surgery they performed.

- If a subsequent surgery results in overlapping follow up periods, the circumstances of the situation determine the length of the follow up care period for the patient. Use the following examples as a guide. In all examples, assume the patient's original surgery has a 90-day follow up period.
    1. If a minor surgery with 10 follow up days is performed on day 45, the original 90 day period will be used as the global follow up period.
    2. If a minor surgery is performed on day 85 of the original surgery, the 10-day follow up period extends beyond the 90 days of the original procedure. Therefore, the follow up period extends through the 10-day follow up for the minor surgery.
    3. If a second major surgery with 90 days follow up is performed on day 80 of the original procedure, a new 90-day follow up period will begin again with the second surgery.

- Modifier 58 is not used to report the treatment of a problem or complication that requires a return to the operating room. (Refer to modifier 78.)

Both modifiers 58 and 78 are used when "related" procedures are performed. The distinct differences in the modifier usage is:

Modifier 58 should be used when…	**Modifier 78 should be used when…**
⇒ a surgery is planned prospectively at the time of the original procedure. ⇒ a surgical procedure more extensive than the original procedure is required. ⇒ therapy following a diagnostic surgical procedure is performed.	⇒ during the postoperative period, a second procedure most commonly due to a complication of the original surgery requires a return to the operating room (OR) and is directly associated with the performance of the original procedure.

Coding Guidelines

- All codes on the major and minor lists can be billed with modifier 58 with the exception of the multiple session codes listed below. Major surgery and minor surgery code lists are published in the April, 1999 Medicaid bulletin.

- The following multiple session codes **should not** be used with modifier 58.

65855	66840	67105	67208	67220
66761	67031	67141	67210	67227
66762	67101	67145	67218	67228
66821				

Modifier 78: Return to the Operating Room for a Related Procedure During the Postoperative Period

Applicable Providers

- Physicians, all specialties
- Optometrists
- Podiatrists
- CRNA
- Multi-specialty Clinics
- Nurse Practitioners
- Nurse Midwives

General Information

Modifier 78 indicates the **return to the operating room (OR)** for a related procedure, by the same or different provider, during the postoperative period of the original procedure. A return to the OR is most commonly due to a complication of the original surgery, but is not limited to treatment of a complication. The procedure must be directly related to the original procedure. Modifier 78 is appended to the subsequent procedure only.

When a procedure code is billed with modifier 78 appended, a new postoperative period is not applied. The reimbursement for a procedure appended with modifier 78 is based on the intraoperative portion of the service.

Policy

Procedures billed by the same provider within the postoperative period of an original procedure are considered part of the global surgical reimbursement package. Modifiers that indicate related or unrelated procedures during the postoperative period are 58, 78 and 79. In order to receive reimbursement for related or unrelated procedures during the postoperative period, modifier 58, 78 or 79 must be appended to the procedure code. Procedures are considered outside of the global package if they are:

1. a related or staged procedure (modifier 58),
2. a procedure requiring a return trip to the operating room during the postoperative period (modifier 78), or
3. an unrelated procedure during the postoperative period (modifier 79).

If one of these modifiers is not appended, the service will be denied as included as part of the global period.

Modifier 78 is used if a procedure is billed by the same or different provider **within the postoperative period** of the original procedure, and requires a return trip to the OR.

An operating room is described as a place of service specifically equipped and staffed for the sole purpose of performing procedures. This can include cardiac catheterization suites, laser suites, endoscopy suites and ambulatory surgery centers. It **does not** include a patient's room, a minor treatment room, recovery room or special care unit such as CCU, ICU,or NICU.

Billing

- Some CPT codes are defined as treatment for complication to a primary procedure (such as bleeding or hemorrhage). If a complication arises during the postoperative period and **requires a return trip to the OR**, modifier 78 should be appended. (Postoperative day "1" begins the day following surgery.) If a procedure rendered due to a complication is handled during the original operative session, the service is billed as a multiple surgery with modifier 51.

Modifier 78 example: A single vessel coronary artery graft is performed on July 1. The next day (postoperative day "1"), the patient's vital signs are unstable and the nurse observes that hemorrhagic complications following the surgery occurred. The patient is returned to the operating room to locate and control the source of hemorrhage. Procedure code 33510, *coronary artery bypass, vein only; single coronary venous graft*, is billed with date of service July 1. Procedure code 35820-78, *exploration for postoperative hemorrhage, thrombosis or infection; chest,* is billed with date of service July 2.

- Modifier 78 is **only** used during the postoperative period, which begins the day following surgery. If the second surgical procedure is done on the day of surgery, it is billed with modifier 51 to denote multiple surgery.

Modifier 51 example: A single vessel coronary artery graft is performed on July 1. That evening, on the **same day**, the patient's vital signs are unstable and the nurse observes that hemorrhagic complications following the surgery occurred. The patient is returned to the operating room to locate and control the source of hemorrhage. Procedure code 35820, *Exploration for hemorrhage, thrombosis or infection; chest,* is billed for the original graft procedure and 35820-51 is billed. The date of service for both procedures is July 1.

- Do not use modifier 78 if the procedure performed for a complication is a repeat of the original procedure. (Refer to modifiers 76 and 77 for guidelines on repeat procedures.)

- Modifier 78 is appended to major and minor surgical procedures only, not E/M codes.

Coding Guidelines

- All codes on the major and minor lists can be billed with modifier 78 with the exception of the multiple session codes listed below. Major surgery and minor surgery code lists are published in the April, 1999 Medicaid bulletin.
- Multiple session codes **should not** be used with modifier 78. The following codes describe procedures that require one or more services in order to complete the procedure. The fee schedule amount allows for each segment included in the procedure, therefore, additional reimbursement cannot be given per session.

65855	66840	67141	67210	67227
66761	67031	67145	67218	67228
66762	67101	67208	67220	
66821	67105			

Modifier 79: Unrelated Procedure or Service by the Same Physician During the Postoperative Period

Applicable Providers

- Physicians, all specialties
- Optometrists
- Podiatrists
- CRNA
- Multi-specialty Clinics
- Planned Parenthood
- Nurse Practitioners
- Nurse Midwives

General Information

Modifier 79 is used with major or minor surgical procedures to indicate an unrelated procedure was performed by the same provider during a postoperative period of the original procedure. If the unrelated procedure has postoperative days, the follow-up period will start over with the new procedure.

Policy

Procedures billed by the same provider within the postoperative period of an original procedure are considered part of the global surgical reimbursement package. Modifiers that indicate related or unrelated procedures during the postoperative period are 58, 78 and 79. In order to receive reimbursement for related or unrelated procedures during the postoperative period, modifier 58, 78 or 79 must be appended to the procedure code. Procedures are considered outside of the global package if they are:

1. a related or staged procedure (modifier 58),
2. a procedure requiring a return trip to the operating room during the postoperative period (modifier 78), or
3. an unrelated procedure during the postoperative period (modifier 79).

If one of these modifiers is not appended, the service will be denied as included as a part of the global period.

Modifier 79 is used when an unrelated procedure is billed by the same provider within the postoperative period of the original procedure.

Billing

- Modifier 79 indicates the procedure is unrelated to the original service or procedure. Example: A total knee replacement (27447) is performed. Within the 90-day follow-up for the knee replacement, care for a colles fracture of the wrist (25620) is provided. Procedure code 25620-79 should be submitted.

- Modifier 79 is intended for use by the operating surgeon only.

- Modifier 79 is appended to major and minor surgical procedures **only**. It is not to be used on evaluation and management (E/M) codes.

- All unrelated procedures performed within the postoperative period should be billed with modifier 79. (E.g., if three unrelated procedures are rendered, all three are appended with modifier 79. If they are rendered on the same day, one is identified as the primary with no modifier 51 and the other two “secondary” procedures are further appended with modifier 51 to designate multiple procedures.)

- If a subsequent surgery results in overlapping follow up periods, the circumstances of the situation determine the length of the follow up care period for the patient. Use the following examples as a guide. In all examples, assume the patient's original surgery has a 90-day follow up period.
    1. If a minor surgery with 10 follow up days is performed on day 45, the original 90 day period will be used as the global follow up period.
    2. If a minor surgery is performed on day 85 of the original surgery, the 10-day follow up period extends beyond the 90 days of the original procedure. Therefore, the follow up period extends through the 10-day follow up for the minor surgery.
    3. If a second major surgery with 90 days follow up is performed on day 80 of the original procedure, a new 90-day follow up period will begin again with the second surgery.

Coding Guidelines

- All codes on the major and minor lists can be billed with modifier 79 with the exception of the multiple session codes listed below. Major surgery and minor surgery code lists are published in the April, 1999 Medicaid bulletin.

- Multiple session codes **should not** be used with modifier 79. The following codes describe procedures that require one or more services in order to complete the procedure. The fee schedule amount allows for each segment included in the procedure, therefore, additional reimbursement cannot be given per session.

65855	66840	67105	67208	67220
66761	67031	67141	67210	67227
66762	67101	67145	67218	67228
66821				

Anesthesia Services

Introduction

Medicaid is implementing two modifiers for anesthesia: YA for general anesthesia, and QS for monitored anesthesia. To provide a better understanding of Medicaid anesthesia guidelines, this section will define and provide information on general anesthesia, monitored anesthesia, regional anesthesia, local anesthesia, I.V. sedation and anesthesia stand-by services. It also includes Medicaid policy and billing instructions on anesthesia for OB and sterilization services, anesthesia for ocular and oral procedures, and procedures and services included in the global anesthesia billing package.

General Anesthesia

Definition: A controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including loss of ability to independently maintain airway and respond purposefully to physical stimulation or verbal command. This state is produced by a pharmacologic or non-pharmacologic method or combination thereof.

Medicaid guidelines allow general anesthesia to be billed only by a physician or a Certified Registered Nurse Anesthetist (CRNA). General anesthesia is identified by billing a procedure code plus modifier YA (formerly billed as Type of Service 07) and time units (one minute equals one unit). Each procedure approved for billing with general anesthesia is assigned base units according to the complexity of the procedure. The time units billed plus the assigned base units are used to calculate the reimbursement amount for the anesthesia services.

Anesthesia time involves the **continuous actual physical presence** of the physician or the CRNA with the patient. The time starts when the physician or CRNA begins to prepare the patient for anesthesia care in the operating room or equivalent area. Time ends when the physician or CRNA is no longer in personal attendance (i.e., when the patient may be safely placed under post-operative supervision). The physician or the CRNA must be in constant attendance of the patient. If surgery is delayed and the provider of anesthesia services is not in constant attendance, the time billed must be reduced to reflect the actual time spent with the patient.

Refer to the modifier YA section of this manual for additional information.

Monitored Anesthesia Care (MAC)

Definition: Monitoring of a patient in anticipation of the need for administration of general anesthesia during a surgical or other procedure, requiring careful and continuous evaluation of various vital physiological functions and the recognition and treatment of any adverse changes. MAC also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral and parenteral medications, and provisions of indicated post-operative anesthesia care.

To be reimbursed by Medicaid, monitored anesthesia services must be rendered by an **anesthesiologist** or CRNA. There is no separate reimbursement if the patient is monitored by the physician performing the procedure or by other personnel, such as a circulating nurse, involved in the performance of the procedure. The effective date for coverage is with claims received June 25, 1999.

Monitored anesthesia is billed with the procedure code plus modifier QS and time expended for anesthesia (one minute equals one unit). The procedure codes are assigned base units according to the complexity of the procedure. The time units billed on the detail plus base units are used in calculating the reimbursement amount for the anesthesia services.

Anesthesia time for MAC involves the continuous actual presence of the anesthesiologist or the CRNA with the patient. The time starts when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or equivalent area. Time ends when the anesthesiologist or CRNA is no longer in personal attendance (i.e., when the patient may be safely placed under post-operative supervision). If surgery is delayed and the provider of anesthesia services is not in constant attendance, the time billed must be reduced to reflect the actual time spent with the patient.

Modifier YA should **not** be billed for monitored anesthesia care. Refer to the modifier QS section for additional information on monitored anesthesia care.

Regional Anesthesia

Definition: A nerve or field blocking causing insensibility over a particular area of the body by interrupting the sensory nerve conductivity from that region of the body.

Medicaid incorporates retrobulbar block, epidural, spinal, subarachnoid, subdural, cervical, thoracic, lumbar and caudal injections for anesthetic purposes into the regional anesthesia policy. There is no separate reimbursement if the operating physician performs an anesthesia related service such as an injection of a local or regional block.

If an injection of an anesthetic substance is the form of anesthesia for a procedure, it is billed with the appropriate procedure code (62274-62279 or 67500) **without** modifier YA (general anesthesia) or QS (monitored anesthesia). Time units are not billed. These injection procedures (most commonly epidurals) are not allowed on the same day as general anesthesia or monitored anesthesia unless the injection or insertion of the catheter follows the procedure and is performed only for pain management. In this situation, the appropriate procedure code should be billed with modifier 59 to denote the service is unrelated to the surgical procedure. Medicaid's current policy regarding injection of medication through the epidural catheter (code 01996) or the limitation of one epidural catheter placement every four days remains the same.

Epidural anesthesia administered for postoperative pain and intractable pain is covered. The initial puncture, placement of the catheter, and injection should be coded to CPT 62278 or CPT 62279. Follow-up injections through the existing catheter should be coded to 01996, "Daily management of epidural or subarachnoid drug administration." Only one follow-up code (01996) is allowed per day, and includes all related services performed on that day, such as the visit, removal or adjustment of the catheter, dose calculation, and administration of the drug. These procedures should not be billed for Patient Controlled Anesthesia (PCA), which is non-covered.

Local Anesthesia

Definition: Anesthesia affecting a local area only.

Local anesthesia billed as a separate procedure is non-covered. The administration of local anesthesia is included in the fee for the procedure, therefore there is no separate reimbursement if the operating physician performs an anesthesia related service such as an injection of a local or regional block.

IV Sedation

Definition: A process of allaying nervous excitement, usually effected by means of a drug.

The administration of IV sedation alone is a non-covered Medicaid service. If the administration of the IV sedation is followed by the constant monitoring of the patient by an anesthesiologist or CRNA who is in **constant attendance** during the surgical procedure, the anesthesia services should be billed as monitored anesthesia, not IV sedation.

Anesthesia Stand-By

Definition: The process whereby the physician or CRNA is on-call or is standing by until it is determined that their services are required to administer and/or monitor anesthesia.

The Medicaid program pays only for the rendering of direct personal services. Being available on a "stand-by" or "on call" basis is not considered a direct personal service, and therefore is not reimbursable. If surgery is undertaken, and the physician or CRNA is called upon to administer and/or monitor anesthesia, then the appropriate procedure code should be billed with either modifier YA or QS appended. Payment is dependent upon meeting specific guidelines for general or monitored anesthesia.

The CPT code 99360, "physician standby service" is not to be billed to represent any anesthesia services**. This code is covered by Medicaid only for high risk or cesarean delivery.**

Anesthesia for OB and Sterilization

Epidural, spinal, pudendal, or caudal anesthesia administered during labor or at the time of delivery is not included in the charge allowed for delivery. Additional reimbursement will be allowed for the physician or his/her designated assistant when one of the following procedures is administered.

SERVICE	CODE	UNITS
Delivery only under epidural	00955	1
Sterilization only under epidural	W8208	1
Delivery and sterilization both under epidural	00955 & W8208	When 00955 & W8208 are billed on the same DOS, reimbursement for code W8208 will be cut-back to $95.70, to reflect monitoring only.
Delivery under epidural, sterilization under general	00955 & W5075	1 unit of 00955, W5075 by time
Delivery under general, sterilization under epidural	Appropriate delivery code & W8208	Delivery code by time, 1 unit for W8202
Delivery only, under general	Appropriate delivery code	Bill by time
Sterilization only, under general	W5075	Bill by time
Delivery and sterilization both under general (same date of service)	Appropriate delivery code and W5075.	Bill by time

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Anesthesia for Ocular and oral Procedures

Ocular and oral procedures may require general, regional, or monitored anesthesia care if appropriate for a medically necessary covered service. Any ocular or oral procedure performed under general or monitored anesthesia is subject to the same rules that apply to any other surgical procedure. For accurate reimbursement when appending modifiers QS or YA, an ocular procedure code must be billed with the ocular diagnosis code, and an oral procedure code must be billed with an oral diagnosis code.

If an **ocular** procedure code is billed, one of the following diagnosis codes must be included on the claim.

171.0	365.20 - 365.23	373.02
173.1	365.41 - 365.44	373.11 - 373.13
173.3	365.51 - 365.59	374.00 - 374.46
190.0 - 190.9	365.60 - 365.65	374.85 - 374.87
198.4	365.81 - 365.89	375.00 - 375.03
198.89	366.00 - 366.11	375.30 - 375.89
215.0	366.13 - 366.18	378.00 - 378.32
216.1	366.20 - 366.23	378.40 - 378.45
216.3	366.30	378.50 - 378.55
224.0 - 224.9	366.32 - 366.34	378.60 - 378.63
232.1	366.40 - 366.46	378.71 - 378.73
232.3	366.50	379.04
234.0	366.52	379.05
238.2	366.53	379.23 - 379.29
238.8	366.8 - 366.9	379.32 - 379.39
360.00 - 360.19	368.2 - 368.30	379.50 - 379.51
360.30 - 360.34	368.32	379.54 - 379.56
360.41 - 360.43	369.9	743.30 - 743.34
360.50 - 360.59	370.04 - 370.07	743.42 - 743.44
361.00 - 361.07	370.50 - 370.59	743.46 - 743.48
361.32 - 361.33	370.60 - 370.64	743.61 - 746.65
362.81 - 362.9	371.00	871.0 - 871.9
363.62	371.02	940.0 - 940.9
364.05	371.03	941.02
364.23	371.43 - 371.45	941.12
364.41	371.50 - 371.58	941.22
364.71 - 364.74	371.60 - 371.62	941.32
364.76 - 364.77	371.70 - 371.73	941.42
365.10 - 365.11	372.40 - 372.45	941.52
365.14	372.63	

If an **oral** procedure code is billed, one of the following diagnosis codes must be included on the claim.

140.0 - 145.9	216.0	520.0 - 529.9
198.89	230.0	873.70 - 873.79
210.0	235.1	947.0
210.4		

Global Anesthesia

General and monitored anesthesia services are considered a global package of services that include the usual pre-operative and post-operative visits, the anesthesia services during the procedure, the administration of fluids and/or blood and the usual monitoring services such as ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry. These services will not be reimbursed separately unless they are unrelated and billed with modifier 59. Certain medical/surgical procedures may be performed by the anesthesiologist (e.g. insertion of a Swan Ganz catheter or insertion of a central venous pressure line, etc.) and are allowed separate reimbursement without appending modifier 59.

Procedure Codes Included in Anesthesia

The following procedure codes are considered included in the anesthesia service and will be denied if billed by the same attending provider on the same date of service as a procedure code with modifier YA or QS. If the service is unrelated to anesthesia services, appending modifier 59 to any of these codes will denote the service is unrelated and will allow the service to pay.

31500	36430	64421	91000	93017	93965
31505	36440	64425	91055	93018	93970
31515	36600	64430	91105	93040	93971
31527	36620	64435	92511	93041	93975
31622	36625	64440	92512	93042	93976
31645	36640	64441	92516	93307	93978
31646	62274	64442	92520	93308	93979
36000	62275	64443	92525	93312	94640
36005	62276	64445	92526	93313	94650
36010	62277	64450	92531	93315	94651
36011	62278	64505	92532	93316	94656
36012	62279	64508	92533	93317	94660
36013	64400	64510	92543	93320	94662
36014	64402	64520	92585	93321	94664
36015	64405	64530	92950	93325	94665
36120	64408	67500	92953	93922	94680
36140	64410	90780	92960	93923	94681
36400	64412	90781	93000	93924	94690
36405	64413	90782	93005	93925	94760
36406	64415	90783	93010	93926	94761
36410	64417	90784	93015	93930	94762
36420	64418	90788	93016	93931	94770
36425	64420	90835			

Evaluation and Management Codes Included in Anesthesia

The following evaluation and management (E/M) codes are considered included in the anesthesia service and will be denied if billed by the same attending provider on the day prior to surgery or the same day as surgery.

99201	99215	99232	99243	99261	99281
99202	99217	99233	99244	99262	99282
99203	99218	99234	99245	99263	99283
99204	99219	99235	99251	99271	99284
99205	99220	99236	99252	99272	99285
99211	99221	99238	99253	99273	99288
99212	99222	99239	99254	99274	99358
99213	99223	99241	99255	99275	99359
99214	99231	99242			

Modifier YA: General Anesthesia

Applicable Providers

- Physicians
- Multi-specialty Clinics
- CRNA

General Information

Modifier YA is a state created modifier for use in billing general anesthesia services. In the past, providers were instructed to bill type of service (TOS) 07 in block 24C of the HCFA 1500 claim form. With implementation of modifiers, type of service codes will no longer be required. Because Medicaid does not recognize CPT anesthesia codes, **YA must be appended to each procedure code for which general anesthesia was rendered.**

General anesthesia is defined as a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including loss of ability to independently maintain airway and respond purposefully to physical stimulation or verbal command. This state is produced by a pharmacologic or non-pharmacologic method or combination thereof.

Anesthesia time involves the **continuous actual physical presence** of the anesthesiologist or the CRNA. The time starts when the physician or CRNA begins to prepare the patient for anesthesia care in the operating room or equivalent area. Time ends when the anesthesiologist or CRNA is no longer in personal attendance (i.e., when the patient may be safely placed under postoperative supervision).

Policy

With implementation of modifiers, there is no change in current Medicaid policy regarding injection of medication through the epidural catheter (code 01996) or the limitation of one epidural catheter placement every four days.

Injection of anesthetic substances **are not** allowed on the same day as general anesthesia or monitored anesthesia unless the injection or insertion of the catheter is following the procedure and performed only for pain management. If so, modifier 59 is billed.

There is no change in the Medicaid policy on anesthesia administration for obstetrics and sterilization. Procedure codes 00955 (continuous epidural analgesia for labor and delivery), 01996 (epidural follow-up), and W8208 (epidural anesthesia for sterilization, including catheter placement) are reimbursed at a flat rate; therefore, modifier YA is not appropriate to bill with these codes. (Refer to Anesthesia for OB and Sterilizations in Anesthesia Services.)

Billing

- Billing for general anesthesia services includes the administration of fluids and/or blood and the usual monitoring services during the procedure. (Usual monitoring services include ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry.)

- Modifier YA is appended to the same primary procedure code that is billed by the operating physician. If multiple surgical procedures are performed on the same day, only the primary procedure code is billed for anesthesia services. The total time for all procedures should be added together and billed on the single code/detail.

- When billing anesthesia time, one minute equals one unit.

- The time units billed on the detail (one minute equals one unit) plus base units (assigned to each procedure code depending on the complexity of the procedure) are used to calculate the allowed amount for the anesthesia services.

- Unusual forms of monitoring such as intra-arterial, central venous pressure, and Swan Ganz are not included in anesthesia services and can be billed separately. These procedures should not be billed with YA, QS, or time units.

- The **only** anesthesia modifiers that Medicaid will recognize are YA and QS. HCPCS modifiers AA, AD, AE, QJ, QO, QQ, QX, and QZ are not recognized by Medicaid and if billed, will result in denial.

- Medical records must include documentation of the pre-anesthetic examination and evaluation, documentation of the monitoring of the patient's vital physiological signs and post-operative anesthesia notes.

The following chart contains common scenarios in billing modifier YA

SITUATION	BILLING GUIDELINE	MODIFIER USAGE
Surgery is terminated prior to the induction of an anesthetic agent, but after the pre-anesthesia exam.	Bill the appropriate evaluation and management (E/M) code.	No appended modifiers.
Surgery is terminated after the induction of anesthesia was started.	Bill claim with the procedure code, modifier, and time units.	Modifier YA.
The anesthesia service for procedure begins as monitored but results in the administration of general anesthesia.	Bill units to reflect the total time expended during both the monitored portion of the procedure and the time the patient was under general.	Modifier YA only
Certain med/surg procedures billed by physician (e.g., insertion of Swan Ganz catheter or insertion of central venous pressure line).	Bill separately for services, using one unit of service, or the number of services rendered.	Do not use modifier YA or QS.
Injection of an anesthetic substance (most commonly epidurals) for postoperative pain management.	Bill with the appropriate procedure code (62274 - 62279 or 67500).	Modifier 59 appended to denote the service is unrelated to the administration of anesthesia during the surgical procedure.

Coding Guidelines

Anesthesia will be processed as a global service. This means all usual services rendered by the provider administering anesthesia will be included in a single payment. Services included in this global package fee include: evaluation and management services rendered the day of or one day prior to the surgical procedure and certain procedures that are considered part of the rendering of anesthesia services, such as the administration of fluids and/or blood and the usual monitoring services during the procedure.

Refer to the section entitled “Anesthesia Services” for guidelines and procedures and services included in anesthesia.

Modifier QS: Monitored Anesthesia

Applicable Providers

- Anesthesiologists from a Physician Practice or Multi-specialty Clinic
- CRNA

General Information

Modifier QS denotes monitored anesthesia services. "Monitored anesthesia care" (MAC) involves the intraoperative monitoring of the patient's vital physiological signs, in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to surgery. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral and parenteral medications, and provisions of indicated post-operative anesthesia care. Monitored anesthesia services can be rendered only by anesthesiologists and CRNAs.

Monitored anesthesia time involves the **continuous actual physical presence** of the anesthesiologist or the CRNA. The time starts when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or equivalent area. Time ends when the anesthesiologist or CRNA is no longer in personal physical attendance (i.e., when the patient may be safely placed under post-operative supervision).

Injection of an anesthetic substance as the form of anesthesia for a procedure is billed with the appropriate procedure code (62274-62279, 67500) without modifier YA or QS appended. This type of anesthesia is not reimbursed by time, therefore, units should represent the number of services rendered. These injection procedures (most commonly epidurals) are not allowed on the same day as general anesthesia (modifier YA) or monitored anesthesia (modifier QS) unless the injection or insertion of the catheter is subsequent to the procedure and performed only for management of post-operative pain. In this situation, the appropriate procedure code should be billed with modifier 59 to designate the service as unrelated to the surgical procedure. (Refer to Regional Anesthesia in Anesthesia Services.)

Policy

There is no change in current Medicaid policy regarding injection of medication through the epidural catheter (code 01996) or the limitation of one epidural catheter placement every four days. (Refer to Regional Anesthesia in Anesthesia Services.)

Ocular and oral procedures may require general, regional, or monitored anesthesia care, if medically necessary. Oral and ocular procedure codes must be substantiated with appropriate diagnosis codes. Effective with claims received June 25, 1999, Medicaid will implement a monitored anesthesia policy for ocular procedures. (Refer to Anesthesia for Ocular and Oral Procedures in Anesthesia Services.)

Billing

- Billing for monitored anesthesia services includes the administration of fluids and/or blood and the usual monitoring services during the procedure. (Usual monitoring services include ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). If these services are rendered and are unrelated to the administration of anesthesia, refer to modifier 59 for information on billing separately.

- **Monitored anesthesia is reimbursed only to an anesthesiologist or a CRNA.**

- Monitored anesthesia billed by a physician group is allowed only if the attending number on block 33 of the HCFA 1500 claim is an anesthesiologist or CRNA. Monitored anesthesia by an independent CRNA is billed with the CRNA provider number in block 33.

- If multiple surgical procedures are performed on the same day, only the primary procedure code is billed for anesthesia services. The total time for all procedures is added together and billed on the single code/detail.

Example: A revision of an arteriovenous fistula (code 36832) and an anoplasty (code 46700) were performed the same operative session. A CVP line was inserted (code 36491) for monitoring blood and fluid pressures. The total time the patient received monitored anesthesia care was 60 minutes. The anesthesiologist or CRNA would bill as follows:

24A		B	C	D				E	F	G
Dates of service		Place of service	Type of service	Procedure code/ modifier				Diagnosis code	Charges	Days or units
040499	040499	21		36832	QS			395	$950.00	60
040499	040499	21		36491				395	$500.00	1

- Monitored anesthesia services billed by the anesthesiologist or CRNA are billed with the same primary procedure code as billed by the operating physician.

- When billing time, one minute equals one unit.

- Unusual forms of monitoring such as intra-arterial, central venous, and Swan Ganz are not included in anesthesia services and can be billed separately. Modifier 59 does not have to be appended to the procedure code in order to be reimbursed separately.

- Modifier YA and QS is an invalid modifier combination and cannot be billed on the same claim detail. If monitored anesthesia results in general anesthesia, only general anesthesia is billed with combined time units.

- Providers rendering monitored anesthesia services are required to maintain documentation on file for a period of five years. This information must include documentation of the pre-anesthetic examination and evaluation, documentation of the monitoring of the patients' vital physiological signs and a post-operative anesthesia note.

- The only anesthesia modifiers that Medicaid will recognize are QS and YA. HCPCS modifiers AA, AD, AE, QJ, QO, QQ, QX, and QZ will not be recognized and if billed, will result in the claim being denied.

- There will be no separate reimbursement for the **operating physician** if he performs an anesthesia related service such as an injection of a local or regional block.

The following chart has common scenarios in billing modifier QS.

If the situation is …	Then billing instructions include…	Modifier usage…
Surgery is terminated, no monitoring services were performed but pre-anesthesia exam was performed	Bill appropriate E/M code, rather than the surgery code appended with the anesthesia modifiers.	No appended modifiers.
Surgery is terminated after monitoring services begins.	Bill procedure with time units. Reimbursement is determined by the procedure's base units plus time units.	Append modifier QS.
Certain med/surg procedures billed by anesthesiologist (e.g. insertion of Swan Ganz catheter or insertion of central venous pressure line.)	Bill separately for services, using one unit of service, or the number of services rendered.	Do not use modifier YA or QS.

Coding Guidelines

Anesthesia will be audited as a global service. Refer to the section entitled "Anesthesia Services" for guidelines on procedures and services included in anesthesia.

Diagnosis codes should accurately describe the diagnosis, complaints and symptoms of the patient. Medical records must support the diagnosis codes billed. Records should not be submitted to verify diagnosis, but records must be available upon request.

Modifier 59: Distinct Procedural Service

Applicable Providers

- Physicians, all specialties
- Optometrists
- Chiropractors
- Podiatrists
- CRNA
- Independent Lab
- Multi-specialty Clinics
- Planned Parenthood
- Nurse Practitioners
- Nurse Midwives
- Portable X-ray

General Information

Distinct procedural service refers to a procedure or service that is designated in the CPT description as a "separate procedure" and is carried out independently or is considered to be unrelated or distinct from the other services provided at the same session. Modifier 59 should be appended to the specific "separate procedure" to indicate that the procedure is not considered to be a component of another service. At this time, Medicaid will use modifier 59 only to process an unrelated or separate procedure rendered outside the global anesthesia package.

Policy

Anesthesia services: Anesthesia services will be processed as a global service effective with claims received June 25, 1999. The global anesthesia package applies to both general anesthesia and monitored anesthesia. The global package of services includes preoperative visits the day prior to surgery and the usual intra-operative services through the post-operative visit. These services include the usual pre- and postoperative visits, care rendered during the procedure, administration of fluids and/or blood, and usual monitoring services including but not limited to ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry. Do not bill these services separately. Certain medical/surgical procedures performed by the anesthesiologist (e.g., insertion of a Swan Ganz catheter or insertion of a central venous pressure line, etc.) are allowed separate reimbursement. **Medicaid will use modifier 59 only to process an unrelated or separate procedure rendered outside the global *anesthesia* package.** (Refer to Global Anesthesia in Anesthesia Services.)

Procedures other than those included in anesthesia: Medicaid will allow modifier 59 to be billed with other procedure codes for informational purposes with no effect on processing.

Billing

- Procedure codes included in the global anesthesia package are identified in the coding section below. If a service on this list is rendered by the same attending provider within the global anesthesia period and is unrelated to the anesthesia service, modifier 59 must be billed with the procedure code to allow separate payment.

- **If modifier 59 is appended to other procedure codes, it will be viewed as informational only and have no effect on processing or reimbursement.**

Coding Guidelines

- The following codes represent services that are normally included in the global anesthesia package and will not be reimbursed separately. However, if circumstances warrant the service may have modifier 59 appended to identify a distinct procedural service. With modifier 59 appended, the service will be processed independently and will not deny as included in the anesthesia package. Use of modifier 59 to designate a distinct procedural service must be supported in the patient's medical record and are subject to review.
- The following codes are normally included in the global anesthesia package:

31500	36410	64412	64530	92532	93312	93976
31505	36420	64413	67500	92533	93313	93978
31515	36425	64415	90780	92543	93315	93979
31527	36430	64417	90781	92585	93316	94640
31622	36440	64418	90782	92950	93317	94650
31645	36600	64420	90783	92953	93320	94651
31646	36620	64421	90784	92960	93321	94656
36000	36625	64425	90788	93000	93325	94660
36005	36640	64430	90835	93005	93922	94662
36010	62274	64435	91000	93010	93923	94664
36011	62275	64440	91055	93015	93924	94665
36012	62276	64441	91105	93016	93925	94680
36013	62277	64442	92511	93017	93926	94681
36014	62278	64443	92512	93018	93930	94690
36015	62279	64445	92516	93040	93931	94760
36120	64400	64450	92520	93041	93965	94761
36140	64402	64505	92525	93042	93970	94762
36400	64405	64508	92526	93307	93971	94770
36405	64408	64510	92531	93308	93975	
36406	64410	64520				

Modifier 80: Assistant at Surgery

Applicable Providers

- Physicians, all types
- Optometrists
- Chiropractors
- Podiatrists
- CRNA
- Nurse Practitioners
- Nurse Midwives

General Information

Modifier 80 is appended to a procedure code to denote assistant at surgery services.

Policy

Medicaid will pay for the services of an assistant at surgery if the surgery is medically necessary and the surgery is approved for assistant at surgery coverage.

A non-physician practitioner, enrolled with Medicaid as an independent practitioner, may bill as an assistant at surgery when their scope of practice has determined their ability to function as a surgical first assistant.

Assistant at surgery services provided by physician assistants, nurse midwives, and nurse practitioners employed by a physician, physician group practice, or the legal entity that employs the physician may be billed as "incident to services" under the physician's Medicaid provider number.

Billing

- Teaching hospitals are expected to use residents as assistants at surgery. Therefore, they **should not** bill modifier 80 for surgical assistant services. If a resident is not available to perform the duties of an assistant surgeon, the teaching hospital must bill with modifier 82. (See modifier 82 for further information.)
- An assistant surgeon **cannot** bill on the same claim as the primary surgeon.
- Assistant surgeons must follow the same rules as primary surgeons for billing surgical procedures with the appropriate modifiers, such as for multiple surgeries (51) or discontinued procedures (53). Refer to the appropriate modifier section for guidelines.
- An assistant at surgery must bill the same procedure code as the primary surgeon
- If there are two surgeons (identified by appending modifier 62 to the procedure) or a team of surgeons (identified by appending modifier 66 to the procedure), an assistant at surgery will not be allowed.

Coding Guidelines

- Refer to the April, 1999 Medicaid Bulletin for procedure code(s) that can be billed as an assistant at surgery or contact the automated Voice Inquiry System to determine if the procedure code in question can be billed with modifier 80.

Modifier 82: Assistant at Surgery When a Qualified Resident Is Not Available

Applicable Providers

- Multi-specialty Clinics
- Teaching hospitals/Physician Faculty/Staff Practices

General Information

In teaching hospitals it is expected that a qualified resident will be available to assist at surgery. Medicaid **does not** reimburse for residents to assist at surgery in hospitals where an approved training program exists.

Modifier 82 is appended to a procedure code to denote assistant at surgery services only when a qualified resident is **not available** to perform the services.

Policy

If the assistant at surgery services billed by teaching hospitals are rendered by a physician, the situation must be that a **qualified** resident is **unavailable**. Situations where a resident may not be qualified are in exceptional medical, life threatening circumstances (i.e., multiple traumatic injuries requiring immediate treatment) or complex medical procedures (i.e., multistage transplant surgeries). The medical record **must** document the reason a qualified resident was not used.

Medicaid will only pay for the services of an assistant at surgery if the surgery is medically necessary and the surgery is approved for assistant at surgery coverage. (Refer to the April, 1999 Medicaid Bulletin for codes approved for Assistant at Surgery coverage.)

If circumstances are such that a qualified resident is not available, Medicaid will reimburse for assistant at surgery services rendered by a physician or a non-physician practitioner whose scope of practice allows the non-physician to function as a surgical first assistant when billed with modifier 82.

Billing

- Modifier 82 can only be billed by the private diagnostic centers associated with teaching hospitals.
- Assistants at surgery must follow the same rules as primary surgeons for billing surgical procedures with the appropriate modifiers such as for multiple surgeries (51) or discontinued procedures (53). Refer to the appropriate modifier section for guidelines.
- Assistant surgeon services **cannot** be billed on the same claim as the primary surgeon services.
- An assistant at surgery must bill the same procedure code as the primary surgeon.
- If there are two surgeons (identified by appending modifier 62 to a procedure) or a team of surgeons (identified by appending modifier 66 to a procedure) an assistant at surgery will not be allowed.

Coding Guidelines

- Refer to the April, 1999 Medicaid Bulletin for procedure codes that can be billed as an assistant at surgery when a qualified resident is not available or contact the automated Voice Inquiry System to determine if the procedure code in question can be billed with modifier 82.

Modifier 62: Two Surgeons

Applicable Providers

- Physicians, all specialties
- Multi-specialty Clinics

General Information

Modifier 62 denotes "two surgeons". Two surgeons or "co-surgery" refers to two surgeons, usually of different specialties and skills, performing parts of a single procedure (same CPT code).

Policy

Two physicians performing surgery on the same patient at the same operative session, even through the same incision, is not always considered co-surgery. Modifier 62 only applies when the procedures performed are part of and would be billed under the same surgical procedure code. **Modifier 62 is not to be used to report an assistant surgeon. If modifier 62 is appended, it denotes co-surgeons. The additional physician is acting as a second surgeon, not an assistant.**

If there are "two surgeons" (co-surgeons) billing for a procedure, Medicaid will **NOT** allow payment for an assistant surgeon.

Billing

- When medical necessity exists for two surgeons, both must bill the same procedure code and date of service, and both must append modifier 62. The fee schedule amount is increased by 25% and reimbursement is split equally between the two surgeons.

- Assistant surgeons DO NOT append modifier 62; an assistant surgeon is not considered a co-surgeon. (If the physician is serving as an assistant, he should append modifier 80 or 82. The primary surgeon cannot bill as a co-surgeon when an assistant surgeon is billed.)

The following chart has common scenarios in billing modifier 62.

Current claim being processed	History claim previously processed	Claim action taken by Medicaid
Procedure code 21270 Modifier 62 billed	Procedure code 21270 No modifier 62 billed Same or different attending provider	Medicaid will deny the claim billed with modifier 62. The surgical procedure has been previously paid as a single surgeon.
Procedure code 21270 No modifier 62 billed	Procedure code 21270 Modifier 62 billed Same date of service Same or different attending provider	Medicaid will pay the current claim and will recoup the previously paid claim. The procedure code on the current claim is billed as a primary surgeon.
Procedure code 21270 Modifier 62 billed	Procedure code 21270 Modifier 80 (or 82) billed Same date of service Different attending provider	Medicaid will pay the current claim and recoup the assistant in history. Medicaid will not allow an assistant surgeon if co-surgeons performed the surgery.
Procedure code 21270 Modifier 80 (or 82) billed	Procedure code 21270 Modifier 62 billed Same date of service Different attending provider	Medicaid will deny the current claim. Medicaid does not allow an assistant surgeon if co-surgeons perform the surgery.

Coding Guidelines

Contact the automated Voice Inquiry System to determine if the procedure code in question can be billed with modifier 62.

Modifier 66: Surgical Team

Applicable Providers

- Physicians, all specialties
- Multi-specialty Clinics

General Information

Modifier 66 appended to a procedure code denotes that a surgical procedure was performed by a surgical team of **three** or more physicians. It identifies a major service that requires the expertise of the surgical team plus other highly skilled, specially trained personnel and the use of various types of complex equipment to perform a procedure. The same procedure code, date of service and place of service should be billed by each member of the surgical team. Modifier 66 is **not** to be used if there are only **two** physicians involved.

Policy

Medicaid will allow payment for a surgical team of three or more surgeons. Reimbursement will be divided equally among the surgeons. Medicaid will **NOT** allow payment for an assistant surgeon if there are a team of surgeons billing for the procedure and modifier 66 has been appended. **Modifier 66 is not to be used to report an assistant surgeon.**

Billing

- All surgeons must bill the same procedure code, same date of service, and same place of service with modifier 66 appended.
- When a team of surgeons is required for a procedure, the fee schedule amount is increased by 25% and reimbursement is split equally among the number of surgeons on the team.
- Assistant surgeons MUST NOT append modifier 66. An assistant surgeon is not considered one of the surgical team and separate reimbursement for an assistant surgeon is not allowed.
- Many of the procedure codes to be billed with modifier 66 are major organ transplant codes. The process for billing major organ transplant procedures will not change. Procedures will still require prior approval from DMA.
- Example of billing modifier 66: A heart transplant, with or without recipient cardiectomy, requires each surgeon to submit CPT code 33945-66 to denote a team approach.

Coding Guidelines

Modifier 66 is acceptable only with the following procedure codes.

22818-22819	50360-50365	61605-61616
32851-32854	61580-61586	61618-61619
33935	61590-61592	63081-63082
33945	61595-61598	63085-63088
47134-47136	61600-61601	63090-63091

Modifier 51: Multiple Procedures

Applicable Providers

- Physicians, all specialties
- Multi-specialty Clinics
- Optometrists
- Podiatrists
- Nurse Practitioners
- CRNA
- Nurse Midwives
- Ambulatory Surgical Centers

General Information

Modifier 51 indicates several procedures were performed on the same day or at the same operative session, by the same provider. Modifier 51 identifies surgical procedures performed in combination, whether through the same or another incision or involving the same or different anatomy. Multiple related surgical procedures or a combination of medical and surgical procedures performed at the same session must be designated with modifier 51.

Policy

Medicaid will not determine the major procedure for the provider. It is the provider's responsibility to correctly identify the primary and secondary procedures in order to be reimbursed appropriately. The primary procedure billed on the first detail of the claim without modifier 51 will be reimbursed at 100% of the allowed amount, and subsequent procedures billed with modifier 51 will be reimbursed at 50% of the allowed amount. Medicaid will not adjust claims for additional payment if the provider neglects to report the major surgery on the first detail.

The assistant surgeon must also bill the primary procedure **without** modifier 51 and subsequent procedures **with** modifier 51. If a patient returns to the operating room for a subsequent procedure on the same day by the same provider, modifier 51 must be appended.

Billing

- The primary procedure is **determined by the billing physician**, and is billed on the first detail of the claim. Modifier 51 is **not** appended. Modifier 51 represents the secondary procedure(s) or service(s) if multiple procedures are performed. Failure to bill modifier 51 on secondary procedures will result in denial of the claim.

- In a multiple procedure situation, the surgeon and the assistant surgeon should identify the same primary procedure by billing that code without modifier 51. All secondary procedures must be billed with modifier 51. It is possible for the surgeon to bill for secondary procedures for which there is no assistant surgeon.

- Medicaid will not adjust for payment if the provider neglects to correctly identify primary and secondary procedures.

- If multiple units of the same procedure are performed on the same day, the procedure code with one unit is billed on the first detail of the claim without modifier 51. The same procedure code and the remaining units are billed on subsequent line(s) with modifier 51 and the appropriate number of units.

- For North Carolina Medicaid, anesthesia is billed using the primary procedure code and is reimbursed through a calculation using both base units and time expended. Therefore, billing modifier 51 on an anesthesia claim is not required but is allowed for informational purposes, and will not affect reimbursement.

- "Add on" codes are those whose CPT description includes phrases such as "each additional" or "list separately in addition to primary procedure." These codes are **not billed** with modifier 51. "Add on" codes will **not** be paid unless the primary procedure is billed and paid. An exception to this is the "add on" codes related to coronary intervention. "Add on" codes 92981, 92984, and 92996 can be billed with any one of the three primary codes of 92980, 92982, or 92995. Please refer to modifier LC, LD, RC for further information on the billing of these codes. A list of "Add on" codes can be found in Appendix E of the 1999 CPT book.

- If billing for multiple endoscopy codes as noted in the November, 1998 Medicaid Bulletin, do not bill with modifier 51. The system will recognize the multiple surgery and price by both endoscopy allowable amounts and multiple surgery allowable amounts.

Modifier 51 **is not** used:	To report an evaluation and management service and a procedure on the same day
	With "add-on" codes for procedures performed in addition to a primary procedure and cannot be performed alone
	To bill separately for procedures and or services that are considered included in the primary procedure
	To identify services rendered by different attending providers
	With multiple endoscopy codes
Modifier 51 **is** used	By the primary surgeon, assistant surgeon and ambulatory surgical facility to indicate that more than one surgery was performed by the same physician on the same patient on the same date of service

Coding Guidelines

- Endoscopy code groups are listed in the November, 1998 Medicaid Bulletin.
- "Add on" codes are listed in Appendix E of the 1999 CPT book.

Modifier 50: Bilateral Procedure

Applicable Providers

- Physicians, all specialties
- Optometrists
- Podiatrists
- Nurse Practitioners
- Multi-specialty Clinic
- CRNA
- Nurse Midwives
- Portable X-ray
- Ambulatory Surgery Center

General Information

Modifier 50 appended to the five-digit procedure code denotes that a procedure was performed bilaterally during a single operative session. This bilateral modifier is used only when the exact same service/code is reported for each site. Modifier 50 may not be appended to procedure codes with descriptions that include "bilateral", "unilateral or bilateral", "one or both", or any other wording describing a procedure potentially performed bilaterally.

Policy

Modifier 50 is only to be appended to procedure codes when anatomically bilateral procedures could be performed and there is no wording in the code description to denote the procedure is for one or both sides. Appending modifier 50 signifies that the procedure was performed bilaterally during the same operative session and will reimburse the lesser of the submitted charge or 150% of the fee schedule amount.

Billing

- The detail billed with modifier 50 must have the same "FROM" and "TO" date and will allow only one unit of service.

- If the same procedure is performed on both sides of the body (and the procedure code is not defined as "bilateral"), the procedure code must be billed on **one** detail with modifier 50 appended. One unit is billed.

Example: Procedure code 27524, *open treatment of patellar fracture*, is performed on both knees. This code does not designate bilateral, therefore appending modifier 50 is appropriate.

24A		B	C	D				E	F	G
Dates of service		Place of service	Type of service	Procedure code/ modifier				Diagnosis code	Charges	Days or units
042899	042899	21		27524	50				970.00	1

- Do not append modifier 50 if a procedure is described in the CPT book as a bilateral procedure and the physician performs only a unilateral procedure. Append modifier RT or LT to denote on which (one) side of the body the procedure was performed. Modifier RT or LT is not allowed on the same detail as modifier 50, and modifiers RT and LT are not allowed on the same detail. (Refer to modifiers RT and LT for additional information.)

Example: Append modifier RT to procedure code 27392, *tenotomy, open, multiple tendons, bilateral*, for surgery performed on the right leg only.

24A		B	C	D				E	F	G
Dates of service		Place of service	Type of service	Procedure code/ modifier				Diagnosis code	Charges	Days or units
050199	050199	21		27392	RT				270.00	1

Procedure code 27392 is defined in the CPT as "bilateral", therefore, do not append modifier 50 to surgery performed on both legs.

24A		B	C	D				E	F	G
Dates of service		Place of service	Type of service	Procedure code/ modifier				Diagnosis code	Charges	Days or units
050199	050199	21		27392					540.00	1

Coding Guidelines

- Read the code definition carefully. Modifier 50 must only be billed with procedures in which the concept of a bilateral procedure is applicable. If the CPT code description includes the term "bilateral", the allowable fee for that procedure is already based on the procedure being performed bilaterally and cannot be appended with modifier 50. If the procedure with code description of "bilateral" was performed unilaterally, these codes should be billed with modifier RT or LT. (Refer to Modifier RT, LT for the correct procedure codes.) If the CPT code description includes the term "unilateral or bilateral" and the service is performed on one side, modifier RT or LT is not required for payment calculation. However, if modifier RT or LT is appended, it will be used for informational purposes only during claims processing.

- The following procedure codes can be billed with modifier 50.

15820-15823	23400	27580-27656	30901-30903
19000-19125	23412-23680	27657-27676	31000-31032
19140-19240	23800	27687-27848	31050-31087
19290	23930-24220	27870-27894	31200-31230
19316-19396	24330-25210	28043-28060	31233-31294
20100	25230-25250	28086-28090	31708-31715
20150	25300-25301	28100-28103	32664
20600-20610	25315-25931	28110-28124	34001-34501
20802-20808	26040-26045	28130	34510-35045
20824-20838	26070-26075	28190-28193	35091-35162
20931	26100-26105	28238-28280	35201-35390
20937-20938	26121-26123	28290-28302	35450-35476
21010	26130	28315	35501-35536
21050-21070	26185	28400-28445	35546
21077	26546	28750-28805	35551-35636
21086	27000-27071	29065-29131	35642-35761
21240-21243	27086-27156	29260-29280	36000
21280-21282	27161	29345-29515	36010-36012
21480-21490	27170-27193	29580	36014-36100
21615-21616	27220-27266	29705-29710	36200-36217
22216	27280	29750	36245-36247
22226	27284-27286	29800-29909	37207
23020-23107	27299-27386	30110	37650
23125-23350	27400-27566	30115	37700-37735

37780-37785	58345	70130	73562
38500-38542	58760-58770	70190	73564
38700-38720	60540	70332	73580
38760-38770	61154	70336	73590
38790	61250	73000	73592
40720	61330	73010	73600
49495-49572	61340	73020	73610
49590	61490	73030	73615
50320-50340	61580-61581	73040	73620
50365	61584-61585	73060	73630
50390-50398	61590-61597	73070	73650
50551-50630	61690-61613	73080	73660
50684	63020-63042	73085	73721
50715	63191	73090	76511
50780-50800	64721	73092	76512
50815-50820	64744	73100	76513
50840	64761-64766	73110	76519
50860	64802-64818	73115	76529
50940-50980	65091-65766	73120	92070
51535	65770	73130	92225
52007	65772-67715	73140	92226
52320-52325	67901-67924	73200	92230
52330-52334	68200	73201	92235
52337-52338	68760-68761	73202	92240
55400	68801-68815	73220	95934
55600-55650	69220-69222	73221	95936
56316-56320	69420-69436	73525	
56342-56344	69676	73530	
56399	70030	73550	
56640	70120	73560	

Modifier RT, LT: Right Side, Left Side

Applicable Providers

- Physicians, all specialties
- Podiatrists
- Nurse Practitioners
- CRNA
- Nurse Midwives
- Multi-specialty Clinic

General Information

Some CPT code descriptions include wording specific to a "bilateral" procedure or a "unilateral or bilateral" procedure in the definition. When a code is defined by CPT as a "bilateral" procedure or a "unilateral or bilateral" procedure, the allowable reimbursement is based on the procedure being performed bilaterally. Modifiers RT and LT are used to identify procedures performed on the right or left side of the body. By appending RT or LT to a CPT "bilateral" code, reimbursement will reflect that a "unilateral" procedure was performed. A list of these codes can be found under Coding Guidelines in this section.

Policy

If a provider bills a code with a description that states "bilateral" but only one side is performed, modifier RT or LT must be appended to denote on which side the procedure was performed. (Example: code 93970, *Duplex scan of extremity veins…; complete bilateral study*)

A provider may elect to append modifier RT or LT as informational to procedure codes categorized as "unilateral or bilateral" to designate on which side of the body the service was performed. (Example: 58920, *Wedge resection or bisection of ovary, unilateral or bilateral*)

If a code does not specify bilateral, unilateral or bilateral, one or both sides, etc., but could be performed on one or both sides, modifier RT or LT **is not** appended to the code. (Example: 27440, *Arthroplasty, knee, tibial plateau*) These codes will be billed with modifier 50 if performed bilaterally.

Billing

- Modifiers RT and LT cannot be billed on the same detail.
- Neither modifier RT nor LT can be billed on the same detail as modifier 50.
- Procedures performed unilaterally and defined in the CPT code description as "bilateral" must be appended with modifier RT or LT. Appending RT or LT to the "bilateral" CPT code indicates that a "unilateral" procedure was performed in lieu of the "bilateral".
- Codes identified by CPT definition as "unilateral or bilateral" and performed only on one side do not require modifiers RT or LT. However, if modifier RT or LT is appended to codes identified as "unilateral or bilateral", the modifier will be used for informational purposes.

Coding Guidelines

- The following procedure codes can be billed with modifier RT or LT.

27392	52290	58210	63045	73725	76519
27395	52300	58600	63046	75662	76645
33976	54130	58605	63047	75671	92081
33978	54135	58700	63048	75680	92082
35549	54430	58720	69210	75716	92083
40701	55041	58800	70330	75724	92265
40702	55200	58805	71060	75733	93875
40843	55250	58900	71110	75743	93880
42507	55300	58920	71111	75803	93922
42508	55450	58925	73050	75807	93923
42509	55815	58950	73520	75822	93924
42510	55865	58951	73565	75833	93925
51575	56312	58952	73700	75842	93930
51585	56313	61000	73701	76094	93965
51595	56632	61001	73702	76102	93970
51820	57531	61253	73720	76516	

- Listed below are "bilateral" procedure codes as described by CPT definition. The RT or LT modifier, designating the side of the procedure, must be appended if the procedure was performed only on one side.

27392	42510	56632	73520	75724	76519
27395	51575	57531	73565	75733	93875
33976	51585	58210	73700	75743	93880
33978	51595	58950	73701	75803	93922
35549	54130	58951	73702	75807	93923
40701	54135	58952	73720	75822	93924
40702	55041	70330	73725	75833	93925
40843	55815	71060	75662	75842	93930
42507	55865	71110	75671	76094	93965
42508	56312	71111	75680	76102	93970
42509	56313	73050	75716	76516	

- Listed below are unilateral and/or bilateral codes as described by CPT definition. Appending either modifier RT or LT to these codes will provide additional information regarding the procedure. Appending RT or LT to these codes will not affect reimbursement.

51820	55250	58700	58920	63045	76645
52290	55300	58720	58925	63046	92081
52300	55450	58800	61000	63047	92082
54430	58600	58805	61001	63048	92083
55200	58605	58900	61253	69210	92265

Modifier 53: Discontinued Procedures

Applicable Providers

- Physicians, all specialties
- Multi-specialty Clinics
- CRNA
- Nurse Practitioners
- Podiatrists
- Nurse Midwives

General Information

Modifier 53 denotes a discontinued procedure when, under extenuating circumstances or those that threaten the well-being of the patient, the provider elects to terminate the surgical or diagnostic procedure. When necessary, this modifier is appended to indicate that a surgical or diagnostic procedure was started but had to be discontinued **after** anesthesia was induced but before it was completed. Examples of why a procedure would be discontinued are uncontrollable bleeding, hypertensive/hypotensive crisis, arrhythmias, or neurologic impairment.

Modifier 53 is not to be used to report an elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operative suite. In these cases, the procedure cannot be billed.

Ambulatory surgical centers may not bill modifier 53. Ambulatory surgery centers should refer to modifier 73 and modifier 74 for instructions on billing discontinued procedures.

Policy

A provider may elect to discontinue a procedure either after the induction of anesthesia or after initiation of the procedure due to circumstances that put the patient at risk. In these situations, modifier 53 must be appended to the HCPCS code to receive partial payment.

Billing

- Based on the relative value units for diagnostic colonoscopy, code 45378, specific billing guidelines apply when modifier 53 is appended. If procedure code 45378 is discontinued and modifier 53 is appended, the detail will price from the fee schedule allowed amount for procedure code 45330, diagnostic sigmoidoscopy. If code 45378 is billed without modifier 53, it will price with the allowed amount for procedure code 45378.

- If any acceptable procedure code other than 45378 is billed with modifier 53 appended, it will pay at 50% of the allowed amount for the code.

Coding Guidelines

- Modifier 53 is not appended to evaluation and management codes.

- Modifier 53 should not be used with time based codes such as anesthesia, critical care, psychotherapy, or codes that, by definition, state "limited".

- The following are procedure codes used with modifier 53:

10040-69979	70010-79999	80400-80440	85095
85102	85999	86999	89100-89105
89130-89141	89399	90700-90799	90865
90870-90871	90935-90947	91000-91299	92015-92020
92235-92240	92265-92284	92502	92511-92526
92531-99199			

- Use the appropriate ICD-9-CM code that represents the recipient's diagnosis. Do not use ICD-9-CM code V64.1. Code V64.2 or V64.3 can be used as a secondary code in conjunction with the primary diagnosis code.

Modifier 76: Repeat Procedure by the Same Physician

Applicable Providers

- Physicians, all specialties
- Optometrists
- Podiatrists
- Chiropractors
- CRNA
- Independent labs
- Multi-specialty Clinics
- Planned Parenthood
- Nurse Practitioners
- Nurse Midwives
- Portable x-ray
- Ambulatory Surgical Centers

General Information

Modifier 76 is appended to report that a diagnostic procedure or service was repeated by the same provider on the same date of service.

Policy

Modifier 76 is used to indicate that a repeat diagnostic procedure was medically necessary and is not a duplicate billing of the original procedure done on the same date of service.

Billing

- Modifier 76 is to be used only if the subsequent repeat procedure is billed by the same provider on the same date of service and with the same procedure code as the original procedure. In the example of billing for before and after films of a fracture treatment, the "after" films are billed with modifier 76.

- All occurrences of the procedure should be billed on the same claim using separate details. The original procedure is billed without modifier 76 and the repeat procedure(s) is billed with modifier 76.

  Example: A patient complains of fever, coughing up thick purulent sputum, and wheezing. A chest x-ray, single view, frontal (CPT 71010) is performed. Twelve hours later, the patient has no improvement after antibiotic therapy is started. The physician requests another chest x-ray. Aspiration Pneumonia is diagnosed. Modifier 76 indicates the second x-ray is a repeat procedure by the same physician.

24A		B	C	D				E	F	G
Dates of service		Place of service	Type of service	Procedure code/ modifier				Diagnosis code	Charges	Days or units
070199	070199	21		71010	26				$75.00	1
070199	070199	21		71010	26	76			$75.00	1

Coding Guidelines

The following diagnostic procedure codes are the only codes to which modifier 76 may be appended. The service will deny if modifier 76 is billed with any other code:

70010-76999	93278-93350	94799	Q0112
78000-79999	93555-93556	95805-95927	Q0113
80002-87999	93720-93770	95933-95999	Q0116
88104-89399	93797-94070	96100-96111	R0070-R0076
91000-91065	94200-94620	G0001	
93000-93272	94680-94770	Q0111	

Modifier 77: Repeat Procedure by Another Physician

Applicable Providers

- Physicians, all specialties
- Optometrists
- Podiatrists
- Chiropractors
- CRNA
- Independent labs
- Multi-specialty Clinics
- Planned Parenthood
- Nurse Practitioners
- Nurse Midwives
- Portable x-ray
- Ambulatory Surgical Centers

General Information

Modifier 77 is appended to report that a diagnostic procedure or service had to be repeated by a different provider on the same date of service.

Policy

Modifier 77 indicates that a repeat procedure performed by a different provider was medically necessary and is not a duplicate billing of the original procedure done on the same date of service.

Billing

- Modifier 77 is used only if the subsequent repeat procedure is billed by a **different provider** on the same date of service and with the same procedure code as the original procedure. In the example of billing for before and after films of a fracture treatment, the "after" films are billed with modifier 77.

  Example: A motor vehicle accident patient complaining of chest pain radiating to his jaw and arm is transported to a local hospital. An EKG (93000) is performed and an arrythmia is noted. The patient sustained serious injuries that cannot be treated at this hospital and he is transferred to a regional medical center. The patient arrives at the regional medical center with increased chest pain, fever, nausea, and tachycardia. The ER physician performs another EKG to rule out myocardial infarction. Procedure code 93000 appended with modifier 77 should be submitted.

Coding Guidelines

The following diagnostic procedure codes are the only codes to which modifier 77 may be appended. The service will deny if modifier 77 is billed with any other code:

70010-76999	93278-93350	94799	Q0112
78000-79999	93555-93556	95805-95927	Q0113
80002-87999	93720-93770	95933-95999	Q0116
88104-89399	93797-94070	96100-96111	R0070-R0076
91000-91065	94200-94620	G0001	
93000-93272	94680-94770	Q0111	

Modifier SG: Ambulatory Surgical Center (ASC) Facility Service

Applicable Providers

- Ambulatory Surgery Centers
- Birthing Centers

General Information

Modifier SG appended to a procedure code denotes that the charges represent the ambulatory surgical center or birthing center facility charges only.

Policy

OBRA 1980 authorized certain surgical procedures that, although appropriate to be performed in the inpatient hospital setting, could also be safely performed on an ambulatory basis. It allowed a facility fee to be reimbursed to the ambulatory center. In order to indicate the setting, Type of Treatment 15 was required. With the implementation of modifiers, Type of Treatment 15 is replaced with modifier SG to designate the facility fee for approved ambulatory surgery procedures.

Billing

- Modifier SG is billed by ambulatory surgical centers or birthing centers only. Modifier SG cannot be used for physician services.
- Modifier SG, 73 (discontinued outpatient hospital or ambulatory surgical center procedure prior to anesthesia), or 74 (discontinued outpatient hospital or ambulatory procedure after anesthesia) **must** be appended to any procedure code representing facility services.
- Modifier SG **should not** be appended to any ancillary procedures performed in the ambulatory surgical center, e.g., lab, radiology, EKG, etc. These services should be billed either without a modifier to denote the complete procedure or modifier 26 to denote the professional component.

Coding Guidelines

Modifier SG is accepted with all procedure codes currently on the provider's 1999 fee schedule with a Type of Service (TOS) 9 (formerly billed as Type of Treatment "15" on the HCFA 1500 claim form). Procedure codes compatible with modifier SG can be verified through the Voice Inquiry System.

Modifier 73: Discontinued Ambulatory Surgical Center (ASC) Procedure Prior to the Administration of Anesthesia

Applicable Providers

- Ambulatory Surgery Centers
- Birthing Centers

General Information

Modifier 73 is used only by ambulatory surgical centers and birthing centers to denote a procedure was discontinued **prior** to the administration of anesthesia.

Policy

Medicaid will reimburse ambulatory surgical centers and birthing centers for a canceled surgical or diagnostic procedure if it is discontinued due to extenuating circumstances or circumstances that threaten the well-being of the patient. Appending modifier 73 indicates the procedure was canceled subsequent to the patient's surgical preparation, but **prior** to the administration of anesthesia (local, regional block, or general). Surgical preparation includes administration of any pre-operative medications or sedation and placement in the operative suite. Reimbursement for a procedure cancelled at this point is 50% of the allowable for the procedure.

Modifier 73 is not used to report an elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operative suite. In these cases, the procedure should not be billed at all.

Billing

- Modifier 73 is used only by ambulatory surgical centers and birthing centers when the procedure is cancelled before anesthesia. Example: A patient experiences a sudden decrease in blood pressure after receiving pre-operative medications and delivery to the operating suite. Before anesthesia is administered, the procedure is postponed until the patient's condition is more conducive to surgery. Resources have not been expended to the same extent as if anesthesia were fully induced, therefore, reimbursement is allowable at 50%.
- Refer to modifier 53 for physician billing of discontinued procedures.
- A procedure code billed with modifier 73 denotes a discontinued procedure in the **ambulatory surgical center**. Therefore modifier SG is not required on the same detail. However, modifier 73 and SG is a valid combination if billed together.
- The reason for termination of the procedure must be documented in the medical records.

Coding Guidelines

Any procedure approved to be performed in an ambulatory surgical setting formerly billed with Type of Treatment 15 can be billed with modifier 73. Procedure codes compatible with modifier 73 can be verified through the Voice Inquiry System.

Modifier 74: Discontinued Ambulatory Surgical Center (ASC) Procedure After the Administration of Anesthesia

Applicable Providers

- Ambulatory Surgery Centers
- Birthing Centers

General Information

Modifier 74 is used only by ambulatory surgical centers and birthing centers to denote a procedure is discontinued **after** anesthesia is administered or after the procedure is started.

Policy

Medicaid will reimburse ambulatory surgical centers and birthing centers for canceled surgical or diagnostic procedures if discontinued due to extenuating circumstances or circumstances that threaten the well-being of the patient. Appending modifier 74 indicates the procedure was canceled subsequent to the patient's surgical preparation, and **after** the administration of anesthesia (local, regional block, or general) or after the procedure was started. Surgical preparation includes administration of any pre-operative medications or sedation and placement in the operative suite. Reimbursement for a procedure cancelled at this point is not affected.

Billing

- Modifier 74 is used only by ambulatory surgical centers and birthing centers for a procedure terminated after anesthesia was induced. Example: Anesthesia is induced and the physician makes a preliminary incision. At this point, the patient develops a significant cardiac arrhythmia. The anesthesiologist controls the PVCs, but the decision is made to discontinue the procedure due to potential risks to the patient.

- A procedure code billed with modifier 74 denotes a discontinued procedure in the **ambulatory surgical center**. Therefore modifier SG is not required on the same detail. However, modifier 73 and SG is a valid combination if billed together.

- The reason for termination of the procedure must be documented in the medical records.

Coding Guidelines

Any procedure approved to be performed in an ambulatory surgical setting formerly billed with Type of Treatment 15 can be billed with modifier 74. Procedure codes compatible with modifier 74 can be verified through the Voice Inquiry System.

Modifier LC: Left Circumflex Coronary Artery
Modifier LD: Left Anterior Descending Coronary Artery
Modifier RC: Right Coronary Artery

Applicable Providers

- Physicians
- CRNA
- Nurse Practitioners

General Information

Modifiers LC, LD, and RC identify the three coronary arteries for vessel intervention recognized by Medicaid. They are:

Modifier LC: left circumflex coronary artery
Modifier LD: left anterior descending coronary artery
Modifier RC: right coronary artery.

Transluminal coronary interventions are appropriately considered in patients who manifest either acute or chronic signs and symptoms of coronary insufficiency. These patients also have not responded adequately to optimized medical therapy, and aortocoronary bypass is a probative alternative. These patients have objective evidence of myocardial ischemia, and lesions amenable to transluminal intervention, therefore, the transluminal interventions have become a third therapeutic option for these patients.

Policy

When billing for the intervention of more than one vessel, the vessels with the highest complexity of intervention must be billed with the appropriate single vessel code (92980, 92982, or 92995). Intervention into a subsequent vessel must be billed with one of the "each additional" codes (92981, 92984, or 92996). The hierarchy of technical complexity among these three codes is generally:

1. stent placement, code 92980,
2. antherectomy, code 92995, and
3. angioplasty, code 92982.

Medicaid allows only one "single vessel" code per day. Any subsequent vessels must be billed using the "each additional" codes. An "each additional" code will not be allowed unless one of the three "single vessel" codes are billed. These "each additional" codes are also "add on" codes. They are an exception to other "add on" codes in that they can be billed with either of the three "single vessel" codes instead of just the primary procedure code as noted in the CPT book. Reference modifier 51 for additional information on "add on" codes.

Billing

- Codes 92980, 92981, 92982, 92984, 92995, and 92996 must be billed with either modifier LC, LD, or RC to identify the specific vessel.
- There must be an ICD-9-CM diagnosis to identify the cardiac related diagnosis when billing codes 92980, 92981, 92982, 92984, 92995, and 92996.
- Branch vessels are considered an integral part of the three major "parent coronary arteries identified by modifiers LC, LD, and RC. There will be no separate reimbursement for interventions in branch vessels. They are considered a part of and are included in the intervention of the parent vessel.
- Modifiers LC, and LD should not be billed on the same detail as modifiers LT or 50. Modifier RC should not be billed on the same detail as modifiers RT or 50.

Coding Guidelines

The procedure codes below must be billed with either modifier LC, LD, or RC. Failure to append one of these modifiers will result in denial.

92980	92982	92995
92981	92984	92996

Modifiers E1-E4: Eyelids

Applicable Providers

- Physicians, all specialties
- CRNA
- Multi-specialty Clinics
- Nurse Practitioners

General Information

Modifiers E1-E4 are assigned to better identify the exact location of a procedure. Modifiers E1-E4 are appended to procedure codes of services performed on the eyelids to identify the specific area of the procedure.

Modifiers E1-E4 are defined as follows:

E1	Upper left eyelid	E3	Upper right eyelid
E2	Lower left eyelid	E4	Lower right eyelid

Policy

When modifier E1, E2, E3, or E4 is appended to a procedure code, the exact eyelid will be identified for processing. The service will not appear to be a duplicate when the appropriate modifier is used.

Billing

- If the procedure includes multiple eyelids, each eyelid must be billed on a separate detail with the appropriate modifier. Subsequent areas must be billed with modifier 51 denoting multiple surgery if appropriate.

- If the description of the base procedure code already describes a particular eyelid, use the appropriate modifier that describes the same eyelid. For example, procedure code 15820 is described as "Blepharoplasty, lower lid." Only modifiers E2 and E4 are appropriate with this procedure code.

Coding Guidelines

Refer to the CPT code descriptions to determine which procedure codes are appropriate with modifiers E1-E4.

Modifiers F1-F9 and FA: Fingers

Applicable Providers

- Physicians, all specialties
- CRNA
- Multi-specialty Clinics
- Nurse Practitioners
- Portable X-ray

General Information

Modifiers F1-F9 and FA are assigned to fingers to better identify the exact location of a procedure. Modifiers F1-F9 and FA appended to procedure codes will designate the specific digit on which the service or procedure was performed.

Modifiers F1-F9 and FA are assigned as follows:

FA	Left hand, thumb	F5	Right hand, thumb
F1	Left hand, second digit	F6	Right hand, second digit
F2	Left hand, third digit	F7	Right hand, third digit
F3	Left hand, fourth digit	F8	Right hand, fourth digit
F4	Left hand, fifth digit	F9	Right hand, fifth digit

Policy

When modifier F1-F9 or FA is appended to a procedure code, the exact digit will be identified for processing. The service will not appear to be a duplicate when the appropriate modifier is used.

Billing

- If the procedure includes multiple fingers, each digit must be billed on a separate detail with the appropriate modifier identifying that finger. Subsequent digits must be billed with modifier 51 denoting multiple surgery if appropriate. Add-on codes are those whose CPT description includes phrases such as “each additional” or “list separately in addition to primary procedure.” They do not require modifier 51, and are not paid unless the primary procedure is billed and paid. Please refer to modifier 51 for more information on add-on codes.

- If the description of the base procedure code already describes a particular digit, the modifier appended must describe the same digit. For example, code 26641 is defined as closed treatment of dislocation, thumb. This code must be billed with FA or F5.

Coding Guidelines

Refer to the CPT code description to determine which codes are appropriate with modifiers F1-F9 and FA.

Modifiers T1-T9 and TA: Toes

Applicable Providers

- Physicians, all specialties
- Podiatrists
- CRNA
- Multi-specialty Clinics
- Nurse Practitioners
- Portable X-ray

General Information

Modifiers T1-T9 and TA are assigned to the toes to better identify the exact location of a procedure. Modifiers T1-T9 and TA appended to procedure codes of services performed on the toes will identify specifically which toe is undergoing the procedure.

Modifiers T1-T9 and TA are defined as follows:

TA	Left foot, great toe	T5	Right foot, great toe
T1	Left foot, second digit	T6	Right foot, second digit
T2	Left foot, third digit	T7	Right foot, third digit
T3	Left foot, fourth digit	T8	Right foot, fourth digit
T4	Left foot, fifth digit	T9	Right foot, fifth digit

Policy

When modifier T1-T9 and TA is appended to a procedure code, the exact digit will be identified for processing. The service will not appear to be a duplicate when the appropriate modifier is used.

Billing

- If the procedure includes multiple toes, each digit must be billed on a separate detail with the appropriate modifier identifying that toe. Subsequent digits must be billed with modifier 51 denoting multiple surgery if appropriate. Add-on codes are those whose CPT description includes phrases such as “each additional” or “list separately in addition to primary procedure.” They do not require modifier 51, and are not paid unless the primary procedure is billed and paid. Please refer to modifier 51 for more information on add-on codes.

- If the description of the base procedure code already describes a specific digit, use the correct modifier that describes the same digit. For example, code 28505 is defined as open treatment of fracture great toe. This code must be billed with TA or T5.

Coding Guidelines

Refer to the CPT code description to determine which procedure codes are appropriate with modifiers T1-T9 and TA.

Modifier TC: Technical Component

Applicable Providers

- Physicians, all specialties
- Optometrists
- Chiropractors
- Podiatrists
- Multi-specialty Clinics
- CRNA
- Independent Lab
- Planned Parenthood
- Nurse Practitioners
- Nurse Midwives
- Portable X-ray

General Information

Certain procedures are comprised of a combination of a professional component and a technical component. Modifier TC appended to the procedure code reports the technical component of such procedures. Technical component includes the performance of the procedure and ownership of the equipment and supplies.

Policy

Types of physician services that have both a technical and professional component include diagnostic and therapeutic radiology services, certain diagnostic tests that involve a physician's interpretation, and physician pathology services. When the complete procedure for these services is billed, both components are included. However, when the provider renders only the technical component of the procedure, he must bill with modifier TC appended to the procedure code. Only the technical component will be reimbursed.

Modifier TC replaces Type of Treatment "T".

If services are billed in an inpatient or outpatient hospital setting, the physician is allowed only the professional component. The facility is allowed the technical component only.

Billing

- Certain diagnostic tests have codes defining a complete procedure. Other tests have codes that define a professional and an associated technical component of the test. **Do not** bill modifier TC with a procedure code that describes the technical component of the procedure in the code definition. For example, code 93041, *Rhythm ECG, one to three leads, tracing only without interpretation and report,* cannot be billed with modifier TC.

- There are two options for billing both the technical and professional components of a procedure. Reimbursement is the same for either billing option.

  OPTION #1
  Bill the procedure code on one detail **without** modifier TC or 26. This denotes a "complete procedure."

  OPTION # 2
  Bill the procedure code on two separate details, one detail with modifier 26 and the second detail with modifier TC. For example: Detail 1: 76604-**26**, Detail 2: 76604-**TC** . Payment will not exceed the allowed amount for the complete procedure described in option #1.

Coding Guidelines

Modifier TC is accepted with all procedure codes currently on the provider's 1999 fee schedule with a Type of Treatment T. Procedure codes compatible with modifier TC can be verified through the Voice Inquiry system.

Modifier 26: Professional Component

Applicable Providers

- Physicians, all specialties
- Optometrists
- Chiropractors
- Podiatrists
- Multi-specialty Clinics
- CRNA
- Independent Lab
- Planned Parenthood
- Nurse Practitioners
- Nurse Midwives
- Portable X-ray
- Ambulatory Surgical Centers

General Information

Certain procedures are comprised of a combination of a professional component and a technical component. Modifier 26 appended to the procedure code reports the professional component separately. The professional component of a service is the physician's interpretation and report of the results of certain non-surgical procedures such as radiology, diagnostic, and pathology services.

Policy

Types of physician services that have both a technical and professional component include diagnostic and therapeutic radiology services, certain diagnostic tests involving a physician's interpretation, and physician pathology services. When the complete procedure for these services is billed, both components are included. However, when the provider renders only the professional component of the procedure, he must bill with Modifier 26 appended to the procedure code. Only the professional component will be reimbursed.

Modifier 26 replaces Type of Treatment "04".

If services are billed in an inpatient or outpatient hospital setting, the physician is allowed only the professional component. The facility is allowed the technical component only.

Billing

- Type of Treatment 04 should not be billed to designate the professional component.
- The provider using modifier 26 for the professional component must prepare a written report that includes findings, relevant clinical issues, and, if appropriate, comparative data. This documentation must be retained in the patient's medical records for a period of not less than five years.
- Certain diagnostic tests have codes defining a complete procedure. Other tests have codes that define a professional component and an associated technical component of the test. **Do not** bill modifier 26 with a procedure code that describes the professional component of the procedure in the code definition. For example, code 93010, *Electrocardiogram, routine ECG with at least 12 leads, interpretation and report only,* cannot be billed with modifier 26.
- There are two options for billing both the technical and professional components of a procedure. Reimbursement is the same for either billing option; neither will exceed the allowance for the complete procedure.

OPTION #1
Bill the procedure code on one detail **without** modifier TC or 26. This will denote a "complete procedure."

OPTION # 2
Bill the procedure code on two separate details, one detail with modifier 26, and the second detail with modifier TC. For example: Detail 1: 76604-26, Detail 2: 76604-TC. Payment will not exceed the allowed amount for the complete procedure described in Option #1.

Coding Guidelines

Modifier 26 is accepted with all procedure codes currently on the provider's 1999 fee schedule with a Type of Treatment 5 (formerly billed as Type of Service "04" on the HCFA 1500 claim form). Procedure codes compatible with modifier 26 can be verified through the Voice Inquiry System.

Modifier YR: Routine Foot Care

Applicable Providers

- Physicians, all specialties
- Podiatrists
- Multi-specialty
- Nurse Practitioners

General Information

Modifier YR is appended to routine foot care services provided without any qualifying circumstances to justify medical necessity.

The following circumstances demonstrate foot care services that are medically justified and should not be billed with YR appended to the procedure code:

- FECTIONS
- Routine foot care performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of ulcer, wounds or infections
- Routine foot care rendered for treatment of warts on the foot, including plantar warts, to the same extent as services provided for the treatment of warts located elsewhere on the body
- Routine foot care services rendered to a patient with certain systemic conditions. (e.g. peripheral vascular disease, diabetes, etc.)
- Routine foot care services rendered to a patient with mycotic nails, in the absence of systemic conditions, that causes pain and /or secondary infection in the non-ambulatory patient, or results in marked limitation of ambulation, pain, and/or secondary infection in an ambulatory patient

Refer to modifiers Q7, Q8, and Q9 for information on qualifying circumstances and class findings.

Policy

Section 1862(a) (13) (c) of the Social Security Act prohibits payment for routine foot care. These services, including cutting or removal of corns and calluses, trimming, cutting, clipping, and debriding of nails and other hygienic care, are normally considered routine and are not covered by Medicaid. The only circumstances in which routine foot care services can be reimbursed are those that are medically necessary and an integral part of otherwise covered services (such as plantar warts), and/or there exists the presence of metabolic, neurological, and/or peripheral vascular diseases, and/or there is evidence of mycotic nails resulting in pain or secondary infection.

Modifiers Q7, Q8, and Q9 refer to certain categories of physical and/or clinical findings that are consistent with the diagnosis and indicative of severe peripheral involvement. The modifiers were established to allow the provider to report class findings without having to submit additional documentation with the claim. The appropriate modifier should be appended to the specific CPT code. The systemic condition(s) and class findings must be documented in the patients record and available for medical review.

To qualify for routine foot care reimbursement, the patient's medical record must document the following:

1. The recipient is under the active care of a doctor of medicine or osteopathy treating the systemic condition.
2. The date of their last visit.

3. It is hazardous to the recipient to have a non-professional perform routine foot care. A statement in the record that the individual has a systemic condition does not, in itself, indicate the need for a physician's level of service. The severity of the condition and the class findings will indicate the need in the event that records are reviewed for medical necessity.
4. Onychomycosis of the nail does not, in itself, justify the need for a physician's level of service. There must be documentation in the medical record that the mycotic nail has resulted in secondary infection and/or pain in the non-ambulatory patient. Clinical evidence to support mycosis of the nail can include photographs of the foot or descriptive terms indicating mycosis

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Billing

- If billing for **routine** foot care, Modifier YR is appended to the procedure code.
- Paring and cutting of nails (procedure codes 11055, 11056, 11057) for a patient with a systemic condition, must be billed with **both** a class finding modifier (Q7, Q8, or Q9) **and** a diagnosis code describing the systemic condition.
- Trimming of nondystrophic nails for a patient with a systemic condition, procedure code 11719, must be billed with **both** a class finding modifier (Q7, Q8, or Q9) **and** a diagnosis code describing the systemic condition.
- Debridement of nail(s) for a patient with infected mycotic nails and a systemic condition or marked ambulatory limitations due to pain or infection (procedure codes 11720 and 11721) must be billed with diagnosis code **110.1** (mycotic nail). In addition there must be a second diagnosis code representing a systemic condition **or** one of the following diagnosis codes: 681.10, 681.11, 719.77, 729.5, 781.2. In either instance, at a minimum, two diagnosis codes are required. The order in which the diagnosis codes are entered on the claim is not relevant.
- The diagnosis of Planter's warts will no longer be an acceptable diagnosis for billing procedure codes 11055, 11056, and 11057. Per CPT directive, Planter's warts must be billed with procedure codes 17000, 17003, and 17004.
- Codes 11040- 11042 or 11305-11308 billed with modifier YR will be denied as a Medicaid non-covered service. If these codes are billed for other than foot care, the class qualifications and diagnosis requirements do not apply.
- T APPLY.

Coding Guidelines

Procedure codes compatible with modifier YR can be verified through the Voice Inquiry System.

Modifier Q7: One Class "A" Finding
Modifier Q8: Two Class "B" Findings
Modifier Q9: One Class "B" Finding and Two Class "C" Findings

Applicable Providers

- Physician, all specialties
- Podiatrists
- Multi-specialty Clinic
- Nurse Practitioners

General Information

Modifiers Q7, Q8, and Q9 describe certain categories of physical and/or clinical findings that are consistent with a diagnosis and indicative of severe peripheral involvement. Each category represents conditions or "class findings" that are grouped into class "A", "B", or "C". The three modifiers were established to allow the provider to report these "class findings" to indicate the severity of a patient's systemic condition and to justify the medical necessity of a procedure that is usually considered and denied as routine.

Definitions of the Class Findings:

Q7 represents "One Class A Finding". A Class "A" finding is a nontraumatic amputation of the foot or integral skeletal portion thereof.

Q8 represents "Two Class B Findings". Class "B" findings include:

- Absent posterior tibial pulse
- Absent dorsalis pedis pulse
- Advanced trophic changes such as hair growth (decrease or absence), nail changes (thickening), pigmentary changes (discoloration), skin texture (thin, shiny), and skin color (elevation pallor or dependence rubor). Three of these trophic changes are required to equal one class "B" finding.

Q9 represents "One Class B Finding" and "Two Class C Findings". Class "C" findings include:

- Claudication
- Temperature changes (e.g., cold feet)
- Edema
- Paresthesias (abnormal spontaneous sensations in the feet)
- Burning
- Markedly diminished or absent sensation in the foot, secondary to systemic disease or injury resulting in damage to the sensory nerves to the lower extremity

Policy

Section 1862(a) (13) (c) of the Social Security Act prohibits payment for routine foot care. These services, including cutting or removal of corns and calluses, trimming, cutting, clipping, and debriding of nails and other hygienic care, are normally considered routine and are not covered by Medicaid. The only circumstances in which routine foot care services can be reimbursed are those that are medically necessary and an integral part of otherwise covered services (such as plantar warts), and/or there exists the presence of metabolic, neurological, and/or peripheral vascular diseases, and/or there is evidence of mycotic nails resulting in pain or secondary infection.

To qualify for routine foot care reimbursement, the patient's medical record must document the following:

1. The recipient is under the active care of a doctor of medicine or osteopathy treating the systemic condition.
2. The date of their last visit.
3. It is hazardous to the recipient to have a non-professional perform routine foot care. A statement in the record that the individual has a systemic condition does not, in itself, indicate the need for a physician's level of service. The severity of the condition and the class findings will indicate the need in the event that records are reviewed for medical necessity.
4. Information to support the accuracy of the class findings.

Billing

- When billing for codes 11055, 11056, 11057 or 11719, one of these three class finding modifiers (Q7, Q8, or Q9) must be appended or the claim will be denied.

- When billing for codes 11055, 11056, 11057 or 11719 with one of the class finding modifiers, there must **also** be a diagnosis describing the patient's systemic condition.

Coding Guidelines

Procedure codes compatible with modifier Q7, Q8, and Q9 can be verified through the Voice Inquiry System.

Modifier YT: Radiation Therapy

Applicable Providers

- Physicians, all specialties
- Multi-specialty Clinics

General Information

A weekly unit of treatment management is equal to five fractions regardless of whether those fractions are on consecutive days. If, at the final billing of the treatment course, there are three or four fractions beyond a multiple of five, those fractions are paid as another week. If there are only one or two fractions beyond a multiple of five, modifier YT is appended to the appropriate "weekly" management procedure code. There is no separate payment for procedure codes with YT appended. Payment for these services (fractions) are considered as included within the payments which have already been made.

Policy

There are no changes to the existing Medicaid policy regarding radiation treatment delivery or clinical treatment management. Please reference upcoming Medicaid bulletins for more detailed information on billing radiation services.

Billing

- If there are one or two fractions beyond a multiple of five fractions, append modifier YT.
- If the total course of treatment consists of only one or two fractions, use procedure code 77431, *Radiation therapy management with complete course of therapy consisting of one or two fractions only*.
- Do not use procedure code 77431 for one or two fractions beyond a multiple of five. This must be billed only if the **complete course** of therapy consists of just one or two fractions. **DO NOT** append modifier YT to procedure code 77431.
- Refer to the table entitled "Billing Radiation Codes with Modifiers" for guidelines on billing radiation therapy.

Billing Radiation Codes with Modifiers				
Codes/ Description	Component/ Modifier(s)	Billed	Units	Paid
77401-77416, Radiation Treatment Delivery	Technical/ TC	Daily	Can bill multiple units on the same day as long as there is a distinct break in sessions AND individual sessions are of the character usually furnished on different days	Per individual session, per unit
77417, Therapeutic Radiology Port Film(s)	Technical/ TC	Per film	Limit to one per day	No professional reimbursement. Payment included in the weekly manage-ment codes reimbursement
77419-77430, Clinical Treatment Management	Professional/ 26	Per five fractions "weekly"	One unit equals five fractions, regardless of whether those fractions are on consecutive days	Five fractions paid as one unit of the "weekly" code
	Professional/ 26		If there are three or four fractions beyond a multiple of five, bill for an additional "week"	Paid as one additional "weekly"unit
	Professional/ 26 & YT		Append modifier YT only if there are one or two fractions beyond a multiple of five	No additional payment. Payment for the extra one or two fractions is included in the payments already made
77431, Clinical Treatment Management consisting of one or two fractions only	Professional/ 26	Per treatment course (one or two fractions only)	one	Payment includes reimbursement for both fractions

Coding Guidelines

- Procedure codes billed with modifier YT are 77419, 77420, 77425, and 77430.

Modifier Q6: Locum Tenens

Applicable Providers

- Physicians, all specialties
- Multi-specialty Clinics
- Optometrists
- Podiatrists
- Chiropractors
- Nurse Practitioners
- Nurse Midwives
- Independent Labs
- Planned Parenthood
- Portable X-ray
- CRNA

General Information

Providers will retain substitute providers to take over their professional practices when the regular provider is absent for reasons such as illness, pregnancy, vacations, etc. These substitute practitioners are called "locum tenens" practitioners and often do not have their own practice and move to various areas as they are needed. A locum tenens can be any of the above provider types. Services provided by locum tenens are identified with modifier Q6.

Policy

Medicaid will allow reimbursement for services rendered by a locum tenens provider. The regular provider submits the claims for services furnished by the substitute provider and receives payment for the services as though he/she performed them. The regular provider generally pays the substitute a fixed amount per diem. The regular provider identifies the services as substitute provider services by appending modifier Q6 to the procedure code on the claim. Modifier Q6 does not affect payment. The regular provider must keep a record on file of each service provided by the substitute, along with the substitute provider's UPIN. The maximum period of time a substitute practitioner may provide services for the regular provider is 60 consecutive days.

Billing

- Services rendered by a locum tenens are billed with procedure codes and modifiers as any provider would bill PLUS the modifier Q6 appended to the procedure code.
- The services rendered by a locum tenens must be billed under the provider number of the provider replaced by the locum tenens.
- The patient's regular practitioner may submit a claim for covered services of a locum tenens practitioner who is not an employee of the regular practitioner when the following guidelines are met:
  - ⇒ The patient has arranged or seeks services from the regular provider,
  - ⇒ The regular provider is unable to provide the services, and
  - ⇒ The regular provider pays for the locum tenens services on a per diem or similar fee for time basis

Coding Guidelines

Procedure codes compatible with modifier Q6 can be verified through the Voice Inquiry System.

Modifier QW: CLIA Waived Tests

Applicable Providers

- Physicians, all specialties
- Podiatrists
- CRNA
- Independent labs
- Multi-specialty Clinics
- Planned Parenthood
- Nurse Practitioners
- Nurse Midwives
- Portable X-rays
- Ambulatory Surgical Centers

General Information

Under the Clinical Laboratory Improvement Amendments of 1988, all laboratories that examine human specimens for the diagnosis, prevention, or treatment of any disease or impairment, or for assessment of the health of a human being must meet certain requirements to perform the examination. No person may solicit or accept materials derived from the human body for laboratory examination or other procedure unless the laboratory has registered with Clinical Laboratory Improvement Amendments (CLIA) and obtained a certification level.

Many of the requirements are based on the complexity of the tests performed. Laboratory certificates are determined by the level of tests the provider performs, either waived tests, moderate tests, or high complexity tests.

"Waived tests" are test systems that must be simple laboratory examinations and procedures that have an insignificant risk of an erroneous result. These waived tests have been approved by the FDA, and employ simple and accurate methodologies as to render the likelihood of erroneous results. They pose no reasonable risk of harm to the patient if performed incorrectly.

The category of waived tests includes several routine laboratory tests. However, included in the list of "waived tests" are several tests normally classified as moderate level tests that, when performed by a certain manufacturer's test system, waived status is granted. HCFA created modifier QW to indicate that the manufacturer's test system meets the requirements of a CLIA waived test by criteria presented in 42 CFR 493.

Modifier QW can be appended **only** when a procedure is performed using a specific manufacturer's test system determined by HCFA to meet the criteria of a "waived" test. If the same procedure is performed using another method, that lab test does not meet the criteria for waived status and cannot be billed with modifier QW.

Policy

In accordance with federal regulations, Medicaid requires that any provider performing a laboratory examination on a human specimen have a CLIA certificate number on file. Every claim submitted for clinical diagnostic laboratory services requires the CLIA certificate number be reported in block 23 of the HCFA 1500. Providers performing tests that are granted "waived" status require, at a minimum, a certificate of waiver.

Billing

- In order to bill for a "waived" test the provider must have a CLIA certificate on file.
- "Waived" tests include, but are not limited to, urinalysis, fecal occult blood, urine pregnancy tests, hemoglobin, and spun microhematocrit. When one of these waived tests is performed, a modifier is **not** required to indicate "waived" status. Modifier QW is appended to the tests that have been granted a waived status if the test is performed by a certain manufacturer's test system.

Coding Guidelines

- The following procedure codes **can** be billed with modifier QW when a specific manufacturer's test system that has been granted "waived" status by HCFA is used.

80061	82273	82951	83718	85018	86318
80101	82465	82952	83986	85610	86588
81003	82947	82985	84478	86308	87072
82044	82950	83036	85014		

- Refer to the list of most current CLIA "waived" tests in the May, 1999 Medicaid Bulletin. This list will be updated in subsequent bulletins when HCFA releases additional waived tests.

Modifier 90: Reference (outside) Laboratory

Applicable Providers

- Physicians, all specialties
- Optometrists
- Chiropractors
- Podiatrists
- CRNA
- Independent lab
- Multi-specialty Clinics
- Planned Parenthood
- Nurse Practitioners
- Nurse Midwives
- Portable x-ray

General Information

Modifier 90 denotes a diagnostic procedure was performed by a party other than the treating or reporting provider. Appending modifier 90 indicates the procedure was actually performed by an outside entity, i.e., "purchased" from an outside party.

Policy

Since Medicaid reimburses to the provider who rendered the service, "purchased services" are not covered by the Medicaid program. When a physician's office refers diagnostic laboratory work to an outside clinical laboratory, the outside laboratory must bill Medicaid for services they rendered.

Venipunctures performed by the physician for specimens sent to an outside laboratory may be billed to Medicaid. One collection fee is allowed for each recipient, regardless of the number of specimens drawn. The procedure code must be on the billing information for reimbursement. Collection fees for pap smears, throat cultures and capillary punctures are considered part of the evaluation and management service and are not covered separately.

Billing

- Modifier 90 is used **only** if the services billed were performed by someone other than the treating or reporting provider.

- If the service is performed by an employee of the provider, it is considered an "incident to" service, not a "purchased" service. Therefore, modifier 90 is not appended to these procedure codes.

Coding Guidelines

Services billed with modifier 90 will be denied because purchased services are not covered.

Modifier FP: Family Planning

Applicable Providers

- Physicians, all specialties
- Podiatrists
- CRNA
- Independent labs
- Multi-specialty Clinics
- Planned Parenthood
- Nurse Practitioners
- Nurse Midwives
- Portable X-ray
- Ambulatory Surgical Centers

General Information

Modifier FP appended to a procedure code identifies a service was provided for the purpose of family planning.

Policy

Family planning services include those services, procedures, and supplies that enable individuals of childbearing age, including minors considered to be sexually active, to freely determine the size of their families and/or to space their children.

Appending modifier FP to a procedure code has no effect on reimbursement.

Billing

- Modifier FP is appended to any service rendered relating to family planning.
- Appending modifier FP to a procedure code can be utilized in lieu of placing the "F" in block 24H of the HCFA-1500 claim form, but both methods of notification will recognize the service as family planning.

Coding Guidelines

Procedure codes compatible with modifier FP can be verified through the Voice Inquiry System.

Modifier CC: Changed Code

Applicable Providers

- Physicians, all specialties
- Podiatrists
- CRNA
- Independent labs
- Multi-specialty Clinics
- Planned Parenthood
- Nurse Practitioners
- Nurse Midwives
- Portable X-ray
- Ambulatory Surgical Centers

General Information

Modifier CC appended to a procedure code identifies that the procedure code has been changed from what the provider originally submitted on his claim. Modifier CC is appended **only** by the processor for administrative purposes to allow payment on a claim.

Policy

When a procedure code is changed due to an administrative decision, the Division of Medical Assistance (DMA) uses modifier CC to denote that the procedure code was changed to allow the claim to process. No change is made to the actual intent of the provider's original code/procedure.

Billing

- Modifier CC is **only** appended to a procedure code by the processor, not by the provider. Example: A provider renders a service that does not routinely require administration of anesthesia. Because anesthesia is not routinely allowable for the procedure code, the claim is denied. The provider submits an adjustment and, for this individual case, anesthesia is medically necessary and reimbursement is justified. The code submitted by the provider is changed to an "unlisted" code and the claim is processed according to DMA instructions. Modifier CC is appended to advise the provider the code was changed by the payer to facilitate processing. The new procedure code with modifier CC appears on the remittance statement.

Coding Guidelines

At the discretion of the processor, modifier CC can be appended to any procedure code to permit payment for a service which would otherwise not be allowed.

Remittance Statement (RA) Changes

General Information

Implementation of modifier processing for physician and practitioner claims submitted on the HCFA-1500 claim form will reflect some changes in the Remittance and Status Reports (RAs). These changes will be visible effective with the July 6, 1999 checkwrite.

1. With the exception of Healthcheck and Medicare crossover claims, claims processed for providers required to bill with modifiers will not show a detail Type of Service (TOS) field on the RA. Otherwise, the type of service code will continue to be printed. (E.g., hospital RAs or Durable Medical Equipment RAs will continue to display the type of service.)
2. All modifiers presented on the claim details will be printed on the RA regardless of whether the claim was processed to pay or deny.
3. Up to three modifiers per detail will be accepted. If more than three modifiers are submitted, the claim will deny. (Healthcheck claims will continue to process using existing modifier guidelines.)

Paper RA changes

The RA has an additional line for each detail submitted with a modifier. This modifier line immediately follows the associated detail and contains all submitted modifiers.

```
DOE     JOHN   K
                      CO=41 RCC=     CLAIM NUMBER=1098194083890  MED REC=104818
      999832242L   052398 052398    1 - 99431  NORMAL NEWBORN H/P, HOSP OR 1.000    11600
Modifier printed (TOS removed)                  53 54 55
                   052498 052498    1 - 99239  HOSPITAL DISCHARGE DAY MANA 1.000    10000
Modifier printed (TOS removed)                  53 54 55
 1  DEDUCTIBLE=      .00  PAT LIAB=      .00 CO PAY=      .00 TPL=        .00       21600
```

Tape RA changes

Tape RAs will include detail modifiers and a new EOB description record. Submitted modifiers will be included on the claim detail record. The new EOB description record(s) will provide a description of each EOB utilized throughout the RA. The ECS Department at EDS has distributed new tape specifications reflecting these changes to all providers who receive tape RAs, ensuring ample notification of specification changes.

Voice Inquiry System

General Information

The automated Voice Inquiry System allows enrolled providers to readily access data pertaining to the North Carolina Medicaid program. With the implementation of modifiers, information on modifiers is available through the call flow options. The Procedure Code Pricing option is renamed to Procedure Code Pricing and Modifier Information. Modifier-related instructions on procedure code pricing and two new selections, Modifier Code Verification and Procedure Code Modifier Combination Verification, are added. The Prior Approval Information option also includes updated modifier-related instructions.

Procedure Code Pricing

The Procedure Code Pricing option now includes inquiries with modifiers. The current call flow allows for a pricing inquiry with a procedure code and type of treatment. This update does not change the current functionality of the call flow but adds the choice to inquire with a procedure code and modifier.

Modifier Code Verification

The Modifier Code Verification selection within the Procedure Code Pricing and Modifier Information option allows providers to verify specific modifiers approved by the North Carolina Medicaid Program. The system requires the provider to enter a two-digit modifier code. The system then reads the Modifier Master File to determine if the modifier is valid. The provider receives a voice message including the modifier description and the type of modifier (i.e., if the modifier is informational, is required for processing, or is required for pricing). If the modifier is valid for Medicare crossover claims only, is an invalid modifier, or is not recognized by Medicaid, the provider is advised. Using an invalid modifier results in denial of the claim.

Procedure Code/Modifier Combination Verification

The Procedure Code/Modifier Combination Verification selection within the Procedure Code Pricing and Modifier Information option allows the provider to determine if a particular code and modifier can be billed together. The system requires the provider to enter a five-digit procedure code, a two-digit modifier code and a date of service. If the procedure code and modifier code are compatible and the date of service is valid, the provider is advised the combination is valid. If the procedure code and modifier are not allowed together or the combination date is before the effective date or after an end date, the provider is notified the combination is invalid. Using an invalid procedure code/modifier combinations results in claim denial.

Prior Approval

The Prior Approval Information option includes inquiries with modifiers. The current call flow allows for a prior approval inquiry based on a procedure code and type of treatment. This update does not change the current functionality of the call flow but adds the option to inquire with a procedure code and modifier.