Acute Care Surgery Coding for Reimbursement : Modifiers

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Modifiers

- Modifiers are used to indicate that the underlying assumption about a CPT code (i.e., a physician charge to a payer) is altered.
- Modifiers are found in Appendix A of the CPT Manual.[1]
- Most modifiers are applied to procedural CPT codes, some are applied to Evaluation & Management (E&M) services, and a few are applied to both.
- In the case of global surgical package conditions, modifiers indicate charges for services that should ***not*** be considered part of the global package.
- Modifiers commonly employed in Acute Care Surgery include:
    - Modifier 24 (Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period).
        - Applied to E&M services only.
        - Indicates that the E&M service is unrelated to a procedure that has a global surgical package period in effect, and the E&M service was performed during the postoperative period.
        - Examples
            - You are rounding on a patient in the ICU who is on a ventilator, has evolving acute renal failure, addressing his severe coagulopathy and anemia, and is receiving volume infusions for resuscitation. You operated on him yesterday to remove his spleen and resect some injured segments of the intestine, leaving him in discontinuity, and applied a temporary wound vac abdominal closure. Your critical care note (as a 99291 with one or more multiples of 99292 as appropriate and documented) addresses the conditions that make him critically ill (respiratory failure, coagulopathy, acute hemorrhagic anemia, hypovolemia, and acute renal failure) and your management of them. You don't even need to mention the operation in that note; in fact, it's better not to mention it at all as you are only delivering critical care. Add a 24 modifier to the critical care charges because your note is written in the postoperative period, but not on the same day as the operation.
            - You are providing critical care for acute respiratory failure and coma to a patient who was just returned to the ICU for what appears to be a stroke. Your colleague (within the same specialty as you are and is from your practice group) operated on him 88 days ago for a perforated duodenal ulcer, performing a modified Graham patch repair (CPT code 43840: "Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury". In order to bill your critical care, your note should mention the critical conditions he has and what you are doing for them. Despite the operation having been completed over 2 months earlier and despite the fact that you didn't perform the

operation, your critical care note code(s) (99291/99292) must have the 24 modifier applied to them because the patient is still within the 90 day global surgical package period for the procedure and because you and your partner are considered the same individual.

- Modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service).
  - Applied to E&M services only.
  - Indicates that the E&M service is unrelated to a procedure that has a global surgical package period in effect, and the E&M service was performed on the same day as the procedure.
  - This modifier is not used to report an E/M service that resulted in a decision to perform surgery for procedures with 90-day global package periods; this scenario requires Modifier 57.
  - Examples:
    - You insert a central line (CPT 36556) on the same day as a daily ICU E&M service (CPT 99291): the daily visit code needs a "-25" modifier or it doesn't get paid.
    - You perform a comprehensive initial assessment on a trauma patient as well as a Focused Abdominal Sonogram for Trauma (FAST). You bill the history and physical as a CPT 99223 and the ultrasound (CPT codes 76705, 76775, and 76604). You must apply a 25 modifier to the E&M service (99223), or you will only be paid for the ultrasound. This is because the underlying assumption in the ultrasound CPT codes is that performance of the procedures is the only interaction you had with the patient that day, and there are presumably some E&M services built into all procedural codes. By using the 25 modifier, that assumption is counteracted and opens the opportunity to be paid for the extensive E&M service involved in the 99223.
- Modifier 50 (Bilateral Procedures)
  - Applied to procedures performed on the same day on the same patient by the same physician. Without the modifier, only one procedure would be paid. Even if a separate operative note is dictated, transcribed, and signed for each procedure, the 50 modifier must be applied or only one procedure will be paid. The payer receives a list of charges from your billing office. They do not see the actual documentation unless they request it in an audit or in case your billing office seeks to contest a denial of payment.
- Modifier 51 (Multiple Procedures)
  - Applied for operations involving more than one procedure. This is common in trauma surgery, where the surgeon may perform a hepatorrhaphy (CPT 47361) , a small bowel resection and anastomosis (CPT 44120), and a splenectomy (CPT 38100). The highest valued CPT code is billed without a

modifier, while the other procedures have the 51 modifier applied. While the modifier reduces the payment for the other procedures by 20 to 50%, without the modifier they would not be paid at all.

- Modifier 53 (Discontinued Procedure)
  - Applied to procedures that were not completed for any reason after it was started.
  - Commonly employed in damage control situations where a small bowel resection was performed but the anastomosis was not performed due to patient instability.
- Modifier 57 (Decision for Surgery)
  - Applied to an E&M service that resulted in the initial decision to perform a surgical operation (typically one with a 90-day global package period).
  - For example, you evaluate a patient in the emergency room for right lower quadrant pain. You determine from your evaluation of the patient that they have appendicitis. You decide to perform an appendectomy. With the 57 modifier applied to the CPT code for your initial H&P (CPT 99223), you can get paid for that H&P.
  - This cannot be applied to an H&P performed on a patient admitted for an elective operation. The decision to operate in that situation was made several days earlier in the clinic which would have a separate clinic-related E&M charge.
- Modifier 58 (Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period).
  - Indicates that the performance of a procedure or service during the postoperative period was either:
    - planned or anticipated (staged),
    - more extensive than the original procedure, or
    - for therapy following a surgical procedure.
  - Example: relaparotomy for fascial closure following initial damage control laparotomy performed 2 days earlier.
- Modifier 59 (Distinct Procedural Service)
  - Applied to procedures that are performed on the same patient on the same day as another procedure by the same provider (or another provider in the same group and specialty) but is performed
    - In a different session,
    - different procedure or surgery,
    - different site or organ system,
    - separate incision/excision,
    - separate lesion, or
    - separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

        - Example: Percutaneous endoscopic gastrostomy performed on the same day as a tracheostomy, thereby using separate incisions.
    - Modifier 78 (Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period).
        - Applies to procedures performed during the global package period of another procedure that were unplanned at the time of the initial procedure
        - Example: relaparotomy for peritonitis from anastomotic leak
    - Modifier 79 (Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period).
        - Applies to procedures performed during the global package period of another procedure but is unrelated to the other procedure
        - Example: percutaneous gastrostomy and tracheostomy performed one week after a trauma laparotomy with bowel resection and repairs.

Table 1. Summary of global package modifiers for procedures and E&M services

Period affected by the modifier	**Type of CPT Code being modified**	
	Evaluation & Management (E&M)	**Procedure**
Same day as global procedure	-25 (Unrelated; for 0- & 10-day globals) -57 (Decision for surgery; for 90-day globals)	-51 (Multiple procedures) -59 (Distinct procedure)
Any day during global period after the day of the procedure	-24 (Unrelated)	-79 (Unrelated) -78 (Related, unplanned) -58 (Staged, planned)