Modifiers

Claims for dually eligible Medicare and Medicaid enrollees must be submitted to Medicaid with the same modifiers used for the Medicare adjudication. The modifiers in the table in this section indicate modifiers that impact reimbursement or policy.

A modifier provides the means to report or indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code. Modifiers enable providers to apply payment policy established by Louisiana Medicaid.

Providers should refer to the most recent *Current Procedural Terminology* (CPT) manual for procedure codes exempt from certain modifier usage. Not all acceptable modifiers result in action by the claims processing system.

NOTE: Improper use of modifiers to maximize reimbursement and to bypass valid claims editing will subject the provider to administrative sanctions and/or possible exclusion from the Louisiana Medicaid program.

Modifier Table

Modifier	Use/Example	Special Billing Instructions	Reimbursement
22 Unusual Service	Service provided is greater than that which is usually required (e.g., delivery of twins); not to be used with visits or lab codes	Attach supporting documentation which clearly describes the extent of the service	125% of the fee on file or billed charges whichever is lower
24 Unrelated evaluation and management service by the same physician during the post-op period			Lower of billed charges or fee on file

Modifier	Use/Example	Special Billing Instructions	Reimbursement
25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	EPSDT medical screening performed on same date of service and suspected condition identified and referred in-house	When a suspected condition identified during a screening visit and diagnosed/treated by the screening provider during the same visit, only a lower level E&M appended with modifier 25 is allowed~~able~~; otherwise claim will deny Improper use of modifiers to maximize reimbursement and to bypass valid claims editing will subject the provider to administrative sanctions and/or possible exclusion from the Louisiana Medicaid program.	Lower of billed charges or fee on file
26 Professional Component	Professional portion only of a procedure that typically consists of both a professional and a technical component (e.g., interpretation of laboratory or ~~x-ray~~radiology procedures performed by another provider)		Lower of billed charges or 40% of the fee on file
NOTE: Louisiana Medicaid does not reimburse technical component (TC modifier) on straight Medicaid claims. Reimbursement is not allowed for both the professional component and full service on the same procedure.			

Modifier	Use/Example	Special Billing Instructions	Reimbursement
50 Bilateral Procedure (See site-specific modifier policy)	Procedure was performed bilaterally during the same operative session	When "bilateral" is part of the procedure codes description, RT/LT or -50 shall not be used.	Lower of billed charges or 150% of the fee on file
51 Multiple Procedures	More than one procedure was performed during the same operative session	Improper use of modifiers to maximize reimbursement and to bypass valid claims editing will subject the provider to administrative sanctions and/or possible exclusion from the Louisiana Medicaid program.	Lower of billed charges or 100% of the fee on file for primary/ 50% of the fee on file for all others
NOTE: When the -51 modifier has or has not been applied to the appropriate procedure(s), the claims processing system will add or remove the modifier as appropriate and process the claim accordingly. When more than one surgical procedure is performed on a date of service, the modifier -51 must be appended appropriately to the secondary or subsequent procedure(s). With few exceptions, the primary procedure is the most clinically intensive procedure, usually with the highest relative value.			
52 Reduced Services	Service or procedure is reduced at the physician's election	Attach supporting documentation	Lower of billed charges or 75% of the fee on file
53 Discontinued Procedure	Only for use by Free Standing Birthing Centers (FSBC's) when the ~~recipient~~ beneficiary is transferred prior to delivery		50% of the FSBC's facility fee or billed charges, whichever is lower

Modifier	Use/Example	Special Billing Instructions	Reimbursement
54 Surgical Care Only	Surgical procedure performed by physician when another physician provides pre- and/or post-operative management		Lower of billed charges or 70% of the fee on file
55 Postoperative Management Only	Post-operative management only when another physician has performed the surgical procedure		Lower of billed charges or 20% of the fee on file
56 Preoperative Management Only	Pre-operative management only when another physician has performed the surgical procedure		Lower of billed charges or 10% of the fee on file
NOTE: If full service payment is made for a procedure (i.e., the procedure is billed and paid with no modifier), additional payment will not be made for the same procedure for surgical care only, post-operative care only, or preoperative care only. In order for all providers to be paid in the case when modifiers -54, -55, and -56 would be used, each provider must use the appropriate modifier to indicate the service performed. Claims that are incorrectly billed and paid must be adjusted using the correct modifier in order to allow payment of other claims billed with the correct modifier.			
57 Evaluation and management service resulting in the initial decision to perform the surgery			Lower of billed charges or fee on file

Modifier	Use/Example	Special Billing Instructions	Reimbursement
59 Distinct procedural services performed; separate from other services rendered on the same day by the same provider		Improper use of modifiers to maximize reimbursement and to bypass valid claims editing will subject the provider to administrative sanctions and/or possible exclusion from the Louisiana Medicaid program.	Lower of billed charges or fee on file
62 Two Surgeons	Performance of procedure requiring the skills of two surgeons	Attach supporting documentation which clearly indicates the name of each surgeon and the procedures performed by each	Lower of billed charges or 80% of the fee on file
63 Infants less than 4 kg	Indicates a procedure performed on an infant less than 4 kg	Attach supporting documentation if multiple modifiers are used (i.e. 51 and 63)	Lower of billed charges or 125% of the fee on file
66 Surgical Team	Performance of highly complex procedure requiring the concomitant services of several physicians (e.g., organ transplant)	Attach supporting documentation which clearly indicates the name of each surgeon and the procedures performed by each	Lower of billed charges or 80% of the fee on file

NOTE: In order for correct payment to be made in the case of two surgeons or a surgical team, all providers involved must bill correctly using appropriate modifiers. If full service payment is made for a procedure (i.e., the procedure is billed and paid with no modifier), additional payment will not be made for the same procedure for two surgeons or surgical team. Payment will not be made for any procedure billed for both full service (no modifier) and for two surgeons or surgical team. If even one of the surgeons involved bills with no modifier and is paid, no additional payment will be made to any other surgeon for the same procedure. Claims which are incorrectly billed with no modifier and are paid must be adjusted using the correct modifier in order to allow payment of other claims billed with the correct modifier.

Modifier	Use/Example	Special Billing Instructions	Reimbursement
79 Unrelated procedure or service by the same physician during the postoperative period			Lower of billed charges or fee on file
80* Assistant Surgeon			Lower of billed charges or~~:~~ MD's - 20% of the full service physician fee on file.
95 Telemedicine/Telehealth	Services provided via a telecommunications system, see the Telemedicine/Telehealth section	Modifier shall be appended to claims for all services provided via telemedicine/telehealth	Lower of billed charges or 100% of the fee on file.
AS* First Assistant in Surgery: Qualified Phys. Assistant, Nurse Practitioner, Certified Nurse Midwives or Clinical Nurse Specialist			Lower of billed charges or 80% of MD's 'Assistant Surgeon' fee
NOTE: *The list of codes acceptable with the 80/AS modifier is posted on the Louisiana Medicaid website. (See Appendix A for information on how to access this information)			
AT Acute Treatment	Chiropractors use this modifier when reporting chiropractic manipulative treatment~~service 98940, 98941~~		Lower of billed charges or fee on file

Modifier	Use/Example	Special Billing Instructions	Reimbursement
Q5 Reciprocal Billing Arrangement	Services provided by a substitute physician on an occasional reciprocal basis not over a continuous period of longer than 60 days. Does not apply to substitution within the same group.	The regular physician submits the claim and receives payment for the substitute. The record must identify each service provided by the substitute.	Lower of billed charges or 100% of the fee on file
Q6 Locum Tenens	Services provided by a substitute physician retained to take over a regular physician's practice for reasons such as illness, pregnancy, vacation, or continuing education. The substitute is an independent contractor typically paid on a per diem or fee-for-time basis and does not provide services over a period of longer than 60 days.	The regular physician submits claims and receives payment for the substitute. The record must identify each service provided by the substitute.	Lower of billed charges or 100% of the fee on file
TH Prenatal ~~Visits~~Services	Required to indicate ~~E&M~~ pre-natal services ~~rendered in the MD office. This will also exempt the service from the adult evaluation and management visit limit.~~		Lower of billed charges or fee for prenatal services
QW Laboratory	Required when billing certain laboratory codes ~~(refer to Laboratory Section of packet)~~		Lower of billed charges or fee on file

Site Specific Modifiers

Unless specifically indicated otherwise in CPT, providers should use site-specific modifiers to accurately document the anatomic site where procedures are performed when appropriate for the clinical situation. Site specific modifiers LT (Left side)/RT (Right side) should not be used in lieu of modifier -50 (Bilateral procedure).

When billing a site specific modifier, in addition to other modifiers for an applicable procedure code, the site specific modifier should be reported in the first position on the claim.

List of ~~Site~~ Site ~~-~~Specific Modifiers

E1	Upper left, eyelid	LT*	Left side
E2	Lower left, eyelid	RT*	Right side
E3	Upper right, eyelid	LC	Left circumflex, coronary artery
E4	Lower right, eyelid	RC	Right coronary artery
FA	Left hand, thumb	LD	Left anterior descending coronary artery
F1	Left hand, second digit	TA	Left foot, great toe
F2	Left hand, third digit	T1	Left foot, second digit
F3	Left hand, fourth digit	T2	Left foot, third digit
F4	Left hand, fifth digit	T3	Left foot, fourth digit
F5	Right hand, thumb	T4	Left foot, fifth digit
F6	Right hand, second digit	T5	Right foot, great toe
F7	Right hand, third digit	T6	Right foot, second digit
F8	Right hand, fourth digit	T7	Right foot, third digit
F9	Right hand, fifth digit	T8	Right foot, fourth digit
		T9	Right foot, fifth digit

*NOTE: When “bilateral” is part of the procedure code description, RT/LT or -50 shall not be used.