

**CHAPTER 5: PROFESSIONAL SERVICES****SECTION 5.1: COVERED SERVICES****PAGE(S) 8****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**

<b>Modifier</b>	<b>Use/Example</b>	<b>Special Billing Instructions</b>	<b>Reimbursement</b>
<b>22 Unusual Service</b>	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
<b>24 Unrelated evaluation and management service by the same physician during the post-op period</b>			Lower of billed charges or fee on file

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Modifier	Use/Example	Special Billing Instructions	Reimbursement
<p><b>25</b>                      Significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service</p>	<p>EPSDT medical screening performed on same date of service and suspected condition identified and referred in-house</p>	<p>When a suspected condition identified during a screening visit and diagnosed/treated by the screening provider during the same visit, only lower level E&amp;M appended with modifier 25 allowable; otherwise claim will deny</p> <p><b>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.</b></p>	<p>Lower of billed charges or fee on file</p>
<p><b>26</b>                      Professional Component</p>	<p>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 procedures performed by another provider)</p>		<p>Lower of billed charges or 40% of the fee on file</p>
<p><b>NOTE:</b> Louisiana Medicaid does not reimburse technical component on straight Medicaid claims. Reimbursement is not allowed for both the professional component and full service on the same procedure.</p>			

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Modifier	Use/Example	Special Billing Instructions	Reimbursement
<p><b>50</b>  <b>Bilateral Procedure (See site-specific modifier policy)</b></p>	<p>Procedure was performed bilaterally during the same operative session</p>	<p>When “bilateral” is part of the procedure codes description, <b>RT/LT or -50 shall not be used.</b></p>	<p>Lower of billed charges or 150% of the fee on file</p>
<p><b>51</b>  <b>Multiple Procedures</b></p>	<p>More than one procedure was performed during the same operative session</p>	<p><b>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.</b></p>	<p>Lower of billed charges or 100% of the fee on file for primary/ 50% of the fee on file for all others</p>
<p><b>NOTE:</b> 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.</p>			
<p><b>52</b>  <b>Reduced Services</b></p>	<p>Service or procedure is reduced at the physician’s election</p>	<p>Attach supporting documentation</p>	<p>Lower of billed charges or 75% of the fee on file</p>
<p><b>53</b>  <b>Discontinued Procedure</b></p>	<p>Only for use by Free Standing Birthing Centers (FSBC’s) when the recipient is transferred prior to delivery</p>		<p>50% of the FSBC’s facility fee or billed charges, whichever is lower</p>

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Modifier	Use/Example	Special Billing Instructions	Reimbursement
<p align="center"><b>54</b> Surgical Care Only</p>	<p align="center">Surgical procedure performed by physician when another physician provides pre- and/or postoperative management</p>		<p align="center">Lower of billed charges or 70% of the fee on file</p>
<p align="center"><b>55</b> Postoperative Management Only</p>	<p align="center">Postoperative management only when another physician has performed the surgical procedure</p>		<p align="center">Lower of billed charges or 20% of the fee on file</p>
<p align="center"><b>56</b> Preoperative Management Only</p>	<p align="center">Preoperative management only when another physician has performed the surgical procedure</p>		<p align="center">Lower of billed charges or 10% of the fee on file</p>
<p><b>NOTE:</b> 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.</p>			
<p align="center"><b>57</b> Evaluation and management service resulting in the initial decision to perform the surgery</p>			<p align="center">Lower of billed charges or fee on file</p>

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Modifier	Use/Example	Special Billing Instructions	Reimbursement
<p><b>59</b>                      Distinct procedural services performed; separate from other services rendered on the same day by the same provider</p>		<p>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.</p>	<p>Lower of billed charges or fee on file</p>
<p><b>62</b>                      Two Surgeons</p>	<p>Performance of procedure requiring the skills of two surgeons</p>	<p>Attach supporting documentation which clearly indicates the name of each surgeon and the procedures performed by each</p>	<p>Lower of billed charges or 80% of the fee on file</p>
<p><b>63</b>                      Infants less than 4 kg</p>	<p>Indicates a procedure performed on an infant less than 4 kg</p>	<p>Attach supporting documentation if multiple modifiers are used (i.e. 51 and 63)</p>	<p>Lower of billed charges or 125% of the fee on file</p>
<p><b>66</b>                      Surgical Team</p>	<p>Performance of highly complex procedure requiring the concomitant services of several physicians (e.g., organ transplant)</p>	<p>Attach supporting documentation which clearly indicates the name of each surgeon and the procedures performed by each</p>	<p>Lower of billed charges or 80% of the fee on file</p>

**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.

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<p><b>79</b>                      Unrelated procedure or service by the same physician during the postoperative period</p>			<p>Lower of billed charges or fee on file</p>
<p><b>80*</b>                      Assistant Surgeon</p>			<p>Lower of billed charges or: MD's - 20% of the full service physician fee on file.</p>
<p><b>95</b>  <u>Telemedicine/Telehealth</u></p>	<p><u>Services provided via a telecommunications system, see the Telemedicine/Telehealth section</u></p>	<p><u>Modifier shall be appended to claims for all services provided via telemedicine/telehealth</u></p>	<p><u>Lower of billed charges or 100% of the fee on file.</u></p>
<p><b>AS*</b>                      First Assistant in Surgery: Qualified Phys. Assistant, Nurse Practitioner, Certified Nurse Midwives or Clinical Nurse Specialist</p>			<p>Lower of billed charges or 80% of MD's 'Assistant Surgeon' fee</p>
<p><b>NOTE:</b> *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)</p>			
<p><b>AT</b>                      Acute Treatment</p>	<p>Chiropractors use this modifier when reporting service 98940, 98941</p>		<p>Lower of billed charges or fee on file</p>

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<p><b>GT</b> Telemedicine</p>	<p>Services provided via interactive audio and video telecommunications system</p>	<p>Modifier should be appended to all services provided via telemedicine and be documented in the clinical record at both sites.</p>	<p>Lower of billed charges or 100% of the fee on file</p>
<p><b>Q5</b> Reciprocal Billing Arrangement</p>	<p>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.</p>	<p>The regular physician submits the claim and receives payment for the substitute. The record must identify each service provided by the substitute.</p>	<p>Lower of billed charges or 100% of the fee on file</p>
<p><b>Q6</b> Locum Tenens</p>	<p>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.</p>	<p>The regular physician submits claims and receives payment for the substitute. The record must identify each service provided by the substitute.</p>	<p>Lower of billed charges or 100% of the fee on file</p>
<p><b>TH</b> Prenatal Visits</p>	<p>Required to indicate E&amp;M pre-natal services rendered in the MD office. This will also exempt the service from the adult evaluation and management visit limit.</p>		<p>Lower of billed charges or fee for prenatal services</p>

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<p style="text-align: center;"><b>QW Laboratory</b></p>	<p style="text-align: center;">Required when billing certain laboratory codes (refer to Laboratory Section of packet)</p>		<p style="text-align: center;">Lower of billed charges or fee on file</p>

**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 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

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