Modifiers are a way to inform the insurer, Medicare or commercial carrier, that the service billed was not ordinary or routine, that a special circumstance is applicable. Examples include the office visit the day the decision for major surgery was made, an unrelated office visit in the post-op period performed by the same physician, or a complication treated in the OR by the same physician following a related surgery. Medicare has indicated that the use (or misuse) of several modifiers is perhaps one of the most frequent billing errors. A clear understanding of the Medicare rules and definitions is necessary to avoid lost time and revenue.

The following modifiers are most likely to involve the most revenue for the practice: -24, -25, -57, -53, -58, -78, and -79:

- The -24, -25, and -57 modifiers are only appended to office visits (ophthalmic and E&M), consultations, and hospital services.
- Any special circumstances that involve surgical services might need the -53, -58, -78, or the -79 modifier.
- The other applicable modifiers will be saved for a future column.

Same Physician Defined

Several of the modifiers include the phrase “same physician,” which Medicare defines as “Physicians in the same group practice who are in the same specialty” and who “must bill and be paid as though they were a single physician.” Note that Medicare does not state in the same subspecialty. For some carriers or Medicare Administrative Contractors (MACs), the ophthalmic group practice is the “same physician” and includes optometrists. Other carriers or MACs will pay the office visit billed by the optometrist in the same group as the surgeon without the modifier. During a post-payment audit, however, if the visit is not documented as an examination for an
unrelated problem, Medicare will probably request a refund.

**Visit Modifiers: -24, -25, -57**
The first step to determining which modifier applies to the visit is understanding when the office visit occurred in relation to the surgery and the length of the post-op period for the surgical procedure performed. If the post-op period for the planned surgery is 0–10 days and the surgery is on the same day, the correct modifier is the -25 modifier. If the post-op period is 90 days and the surgery is the same day or following day, the -57 modifier is applicable. If the office visit is after the surgery, in the post-op period, the appropriate modifier is the -24 modifier.

- **24: Unrelated E&M service by same physician during a post-operative period.** The post-op modifier -24 is appended to office or hospital codes to indicate that the service was performed during a post-op period for a reason(s) unrelated to the original surgical procedure. This modifier is used for visits performed after either a major or minor surgical procedure. Medicare defines the post-op period as beginning on the first day after surgery and it continues for either 10 or 90 days.

  Modifier -24 would be inappropriate when the patient is complaining of pain and redness in the surgical eye. It would be appropriate if the patient were to complain of pain, itching, and redness in both eyes accompanied by sniffing and sneezing.

  The documentation of the patient’s complaint for any potentially “unrelated” post-op visits, scheduled or unscheduled, is extremely critical. If the unrelated condition is not spelled out clearly in the chart, there is no support for billing the office service in the global fee period.

- **25: Significant, separately identifiable E&M service by same physician on same day as the procedure.** According to Medicare, the modifier -25 indicates that on the day of a minor surgical procedure, the patient’s medical condition requires a significant, separately identifiable service, above and beyond the usual pre- and post-op care associated with a surgical service performed. This modifier is not used for the “decision for surgery” when a minor surgery procedure is performed on the same day. A minor surgical procedure is defined as a procedure that has a 0- or 10-day global fee period as listed on the Medicare Physician Fee Schedule Data Base (MPFSDB). This modifier should not be submitted with encounters that are specifically for new patients because the codes are automatically excluded from the global fee surgery package and are reimbursed separately from the surgery.

  The reason for the office visit can be a symptom or condition for which the procedure is provided. As such, Medicare states that different diagnoses are not required for reporting the E&M services on the same date. That being said, Medicare will probably request additional documentation to substantiate the significant, separately identifiable office service when the same diagnosis is used for the visit and the surgery. It is better to code the office visit with the symptom or condition the patient presented with than the final diagnosis that resulted in the minor surgery.

  One clear-cut example of when to use the -25 modifier is the cataract patient who presents for an annual follow-up examination and is treated with the insertion of bilateral punc-tum plugs for an additional complaint of dry eyes. The not-so-clear-cut example is when the patient is being followed for wet macular degeneration, a recommendation was made during the previous visit to try intravitreal injection of Lucentis if the patient’s vision does not stabilize, and the intravitreal injection is performed during the following encounter. The encounter would not be billable separately. Medicare usually will consider today’s visit a pre-op work-up and an integral part of the minor surgery.

  As a reminder, the E&M service could occur on the same day as a minor procedure and within the post-op period of a previous procedure. Medicare will allow payment when the documentation in the chart supports both the -25 modifier and the -24 modifier—that the office encounter is an unrelated office visit during a post-op global fee period.

- **57: Decision for surgery.** Any E&M service on the day before major surgery, the day of the procedure, and within the 90-day post-op period is usually not payable under Medicare rules. The encounter during which the surgical decision was initially made, however, is billable in addition to the major surgical event. This special circumstance only exists when there was no prior visit during which the surgical decision was made. The -57 modifier must be appended to the visit code when the chart documentation supports its use. Without the modifier, Medicare will deny the charge for the encounter as part of the global surgical fee.

  Once the final decision is made, no subsequent examination can be billed prior to the surgical event, unless surgery was postponed. When this occurs, the record should reflect when the surgery was postponed and why. This will provide support for the billing of a subsequent visit when the new surgical decision is made.

  If surgery is recommended, but not agreed to by the patient, no surgical decision has been made and the modifier is not used. When the patient is advised to return for a follow-up visit and if there is no improvement then surgery will be considered, there is no decision to perform surgery. There is a conditional decision, which means the final decision for surgery will not be made until the following visit.

  Like the -25 modifier, this modifier should not be submitted with encounters that are specifically for new patients because those services are automatically excluded from the global fee surgery package and are reimbursed separately from the surgery.

**Selected Surgical Modifiers: -53, 58, -78, -79**
The following modifiers are appended to only surgical codes to identify special, separately reimbursable circumstances. Unfortunately, these modifiers are frequently overlooked and the practice loses revenue as a result.

- **53: Discontinued procedures.** Modifier -53 is used to identify that the surgeon’s service was started, but had to be terminated due to extenuating circumstances or for the well-being of the patient. This modifier is not used to identify the elective can-

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cellation of a procedure prior to the patient’s anesthesia induction and/or surgical preparation in the operating suite. For ambulatory surgery center (ASC) reporting of a surgery that is partially reduced or canceled as a result of extenuating circumstances prior to or after administration of anesthesia, see the modifiers -73 and -74 in the current CPT manual.

When billing for a discontinued surgery, Medicare often requires submission of additional information such as a copy of the operative note explaining in detail the reason the procedure was discontinued. As a reminder, a procedure can be aborted only if it has begun. In other words, if a surgical opening or incision has not been prepared, the surgeon cannot bill for a service. Some carriers/MACs have indicated that a procedure is billable as “discontinued” only if the documentation submitted indicates induction of anesthesia.

Currently, there are no ophthalmic surgical procedures on the MPSSDB with the -53 modifier. Any discontinued ophthalmic surgeries will be subject to the carriers or MACs medical staff review and paid on an individual basis. The proper documentation to support the -53 modifier is a concise statement that explains why it was medically necessary to discontinue the surgery. The statement can be entered in the electronic documentation field or submitted via the fax attachment process. If your carrier or MAC does not have a fax process, the additional documentation would be submitted with the paper claim.

58: Staged or more extensive procedures by same physician in the post-operative period. This modifier is used to request payment for surgery during the post-op period of another surgical procedure when (1) the subsequent procedure was planned prospectively (staged) at the time of the original procedure, (2) a less extensive procedure fails and a more extensive procedure is required, or (3) a therapeutic surgical procedure follows a diagnostic procedure. Usually the -58 modifier is used in ophthalmology when billing for a more extensive, but related, surgical procedure during the global fee period, such as conservative repair of retinal detachment by pneumatic retinopexy which did not provide a good reattachment of the retina and a vitrectomy with scleral buckle is performed within the 90-day global fee period. The vitrectomy with scleral buckle procedure code would include the -58 modifier. Again, the clinical chart should reflect the failure of the initial treatment and the reason for the more extensive surgery.

Do not append this modifier to any procedure listed in CPT with multiple sessions or stages in the descriptor. Also, if billing for the treatment of a complication from the original surgery that requires a return to the operating room, the more appropriate modifier is the -78 modifier discussed below.

The carrier or MAC will reimburse the surgeon the full allowed fee and start a new global fee period. If this modifier is not appended appropriately, Medicare could deny payment for the service as being related to the original surgery.

78: Return to operating room (OR) by same physician for a related procedure or complication. A surgical correction of any complication of surgery is reimbursable by Medicare during the global fee period provided the procedure was performed in a dedicated OR. Medicare defines an OR as any room especially designed, staffed, equipped, and utilized solely for minor or major surgery. There can be no other equipment in the room except that which is related to the type of surgery being performed. In other words, if the room is used as an interim examination lane or to store the visual fields machine or cleaning equipment, it does not meet the definition of a surgery suite/room or OR.

It is generally very simple to document where a “return to OR” was performed when it was done in the ASC or at the hospital. However, when the procedure is done in the clinic and the place of service is an office, the clinical record must clearly note where the procedure was performed. If no reference is made, Medicare could presume the procedure was in the examination room or lane and deny payment.

For example, the paracentesis of the anterior chamber to relieve a post-op elevated IOP or the suture repair of a wound dehiscence are typically done in the lane under topical anesthesia. The location the surgical procedure is performed, whether in an OR within the clinic or the adjoining ASC, should be noted in the medical record for safety’s sake.

When the -78 modifier is appended to the procedure code, Medicare reimbursement is based on the intra-operative percentage only. A “return to OR” does not begin a new surgical global period. Be warned that if this modifier is appended to a surgical procedure outside the global period, Medicare will still only reimburse 70% for the service and the mistake will cost the practice 30% of the allowed fee.

79: Unrelated procedure during post-operative period. The -79 modifier is used to identify those surgical services that are performed during the post-op period of another surgery and are unrelated to the initial surgery. Unlike the -78 modifier, the location of the surgery is irrelevant when the procedure is unrelated.

What is critical in these situations is to clearly document the reason for the surgery and the condition for which it is being done. The documentation needs to show that it is in no way related to the previous surgery or the condition. The most common circumstance is when the second procedure is performed on the fellow eye. Medicare will reimburse the surgeon the full allowable fee for the unrelated procedure and the use of the -79 modifier will start a new global fee period.

Final Thought

Every physician and biller must be intimately familiar with the definitions and requirements of modifiers when submitting a claim to Medicare. To do otherwise is to forfeit revenue. With the current state of the economy, being unaware of these definitions and requirements can be financially devastating to a practice.