A Facility-Focused Guide to Applying Modifiers Correctly
Date
Webinar FAQ Document

1. **Question-** When is it appropriate to use the JD modifier?

   Answer- Modifier JD, *Skin substitute not used as a graft,* should be appended when the provider uses a skin substitute to cover a wound due to inadequate skin available for coverage. The provider repairs or replaces the defective tissue with an artificial skin substitute that covers the wound. Providers most commonly append this modifier to HCPCS codes for skin substitutes when used to treat wounds, infections, or ulcers. This modifier should be used with HCPCS codes Q4100, *Skin substitute, not otherwise specified,* as well as Q4101-Q4121 and Q4136-Q4137, which are codes that specify brands or types of skin substitutes. Modifier JD should not be used if the provider uses the skin substitute as a graft and not as a covering.[1]

2. **Question-** You only mentioned status indicators S and T procedures in the requirements for using modifier 25. What about the status indicator Q procedures?

   Answer- Status indicators Q1 (STV-Packaged Codes), Q2 (T-packaged Codes) and Q3 (Codes That May Be Paid Through a Composite APC) are interim status code assignments that resolve to a final status indicator depending upon the other codes reported on the claim. When a code with an interim status indicator of Q1, Q2, or Q3 has a final status indicator of S or T and a separately identifiable E/M service is performed, 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*, would be appended. When the final status indicator is something other than S or T, no modifier would be required.

3. **Question-** Can you append modifier 25 or modifier 27 to HCPCS G0463?

[1] HCPCS Level II Expert 2023. AAPC. *Appendix B HCPCS Level II Modifiers, Lay Descriptions, and Tips.*

Answer- Yes, 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,* or 27, *Multiple Outpatient Hospital E/M Encounters on the Same Date,* is appropriate for use with HCPCS code G0463, *Hospital outpatient clinic visit for assessment and management of a patient*.[2]

4. **Question-** When reporting modifier 25 with an E&M code, does the "other" CPT (i.e. repair or lab) have to be on the same day?

   Answer- Yes, the other procedure or service should be on the same date of service as the E&M code. If they are not on the same date of service, 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*, is not necessary. **Also, note that modifier 25 is only required when a procedure code with a final status indicator of S or T is reported on the same date of service.**

5. **Question-** If a patient had a telehealth video in the morning with one provider/department; then had an in person visit later the same day with a *different* provider/department; what modifier would be appropriate?

   Answer- In this case, it may be appropriate to use modifier 27, *Multiple outpatient hospital E/M Encounters on the Same Date.* If the second encounter was not for an E/M visit, but rather a surgical procedure, non-surgical therapeutic procedure, or diagnostic procedure, it may be appropriate to use modifier XE*, Separate Encounter, A Service that is Distinct Because it Occurred During a Separate Encounter.* Note that following the end of the COVID-19 Public Health Emergency (PHE) on May 11, 2023, hospitals will be required to provide services to patients within their hospital departments and may no longer bill for E/M visits when the patient is located outside of the hospital.[3]

---

[2] *2022 CPT Code G0463-Description, Guidelines, Reimbursement, Modifiers & Examples*. Coding Ahead. https://www.codingahead.com/cpt-code-g0463-description-reimbursement-modifiers/

[3] Hospitals and CAHs (including Swing Beds, DPUs), ASCs and CMHCs: CMS Flexibilities to Fight COVID-19, page 4, https://www.cms.gov/files/document/hospitals-and-cahs-ascs-and-cmhcs-cms-flexibilities-fight-covid-19.pdf

6. **Question-** Some payers want us to use modifier 25 and 27 with condition code G0, is this what CMS also request?

   Answer- CMS instructs the use of condition code G0 (Multiple Medical Visits) whenmultiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits for hospitals subject to the Outpatient Prospective Payment System (OPPS)[4]. Note that Critical Access Hospitals would not append Condition Code G0.

7. **Question-** Can you append modifier 50 to an unlisted code?

   Answer- No, according to CPT guidance, it is not appropriate to append modifier 50 to an unlisted code. Unlisted codes do not describe specific procedures, so there is no need to alter the meaning of the code. Keep in mind that some payers have their own rules regarding using modifiers with unlisted codes, so always check with your payer to see what's required.

8. **Question-** Can a bilateral 50 modifier be used when a procedure is on two right fingers? or right hand and right wrist?

   Answer- Modifier 50 should be used to indicate that a procedure was performed on both sides of the body (mirror image) during the same encounter or session.[5] For a procedure performed on two right fingers, it may be appropriate to use the finger modifiers (FA and F1-F9) to identify the appropriate fingers if the procedure code specifically references fingers. For a right hand and a right wrist, it would be appropriate to use modifier XS, *Separate structure, a service that is distinct because it was performed on a separate organ/structure* or modifier 59, *Distinct procedural service*, if the payer does not recognize modifier XS.

---

[4] Medicare Claims Processing Manual, Chapter 4 – Part B Hospital, Section 180.4 – Proper Reporting of Condition Code G0

[5] Coding with Modifiers 6th Edition. A Guide to Correct CPT and HCPCS Level II Modifier Usage. American Medical Association.

9. **Question-** For a hospital outpatient department, would it be better for us to use the CPT twice and code RT and LT to get the full payment for doing a bilateral procedure instead of doing a unit of 1 with a modifier 50?

   Answer- If there is only a unilateral CPT code available and the procedure was performed bilaterally, Medicare requires that modifier 50, *Bilateral Procedures*, be used with a unit of 1. Commercial payers may have their own rules for this situation. If there is a CPT code available with a description that states "bilateral", this code should be used with no modifier. It is never appropriate for a facility to code two unilateral procedures with the RT, *Right side*, and LT, *Left side*, modifiers instead of choosing the bilateral CPT code. This is against Medicare National Correct Coding Initiative (NCCI) guidelines and incorrect from a CPT® coding perspective.

10. **Question-** Is moderate conscious sedation considered anesthesia? Or does it have to be MAC and/or general in order to use -52, *Reduced services*?

    Answer- For billing purposes, moderate conscious sedation is considered anesthesia.[6]

11. **Question-** Should modifier RT/LT generally NOT be used with modifier 59 on the same code?

    Answer- If there is an appropriate anatomic modifier, such as RT, *Right side*, or LT, *Left side*, that could be used to distinguish a service, that should be used instead of modifier 59, *Distinct procedural service.* Generally, it would not be necessary to append both an anatomic modifier and modifier 59.

[6] *Hospital Outpatient Prospective Payment System (OPPS): Use of Modifiers-52, -73 and -74 for Reduced or Discontinued Services.* CMS Transmittal # R442CP. Change Request # 3507. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R442CP.pdf

12. **Question-** Regarding the example of the cardiac stress test and EKG being performed on the same day and using the XE modifier, does separate encounter mean the patient has to leave and come back? Can it be used even when both procedures are done during the same visit/same department but at different times?

    Answer- The patient does not have to leave the facility and come back in order to use modifier XE, *Separate encounter.* Modifier XE can be used to describe two services described by timed codes provided in the same encounter if they are performed one after another. The services should be performed during separate and distinct time periods that are not intermingled (one service must be performed and finished prior to beginning the next service). If the circumstances of the second encounter could be described by a more specific modifier, that should be used rather than modifier XE.[7]

13. **Question-** What is the difference between modifier -74 and modifier -52? What modifier is used, if say a colonoscopy was incomplete (due to tortuous colon) and they only get as far as the sigmoid. This is coded to the 'intended' procedure (45378). Which modifier (-74 or -52) is used for the incomplete procedure?

    Answer- Modifier 52, *Reduced Services*, should be used when a procedure doesn't require anesthesia. It is typically used for the discontinuation of radiology procedures or other services that don't require anesthesia when the procedure performed is less than the requirements of the code description and no alternate code exists.

    Modifier 74, *Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia*, should be used to indicate when a procedure is terminated after administration of anesthesia.

    For billing purposes, anesthesia includes local, regional block(s), moderate sedation (conscious sedation), deep sedation, and general anesthesia.

[7] *Proper Use of Modifiers 59, XE, XP, XS, and XU.* CMS MLN Fact Sheet. MLN1783722. https://www.cms.gov/files/document/mln1783722-proper-use-modifiers-59-xe-xp-xs-and-xu.pdf

In the colonoscopy example, modifier 74 may be appropriate if the procedure was cancelled after the administration of anesthesia due to extenuating circumstances or those that threaten the well being of the patient.

14. **Question-** If multiple EKGs are performed during a single encounter on the same date of service, would modifier -76 be appropriate?

    Answer- Yes, modifier 76, *Repeat procedure or service by the same physician or other qualified health care professional*, would be appropriate if the service was provided by the same physician on the same date of service.

15. **Question-** What if the CMP lab result showed Potassium/Sodium as "hemolyzed", then they re-ran the Potassium/Sodium? Is modifier XU appropriate or is this a charging error due to "testing problems with specimens"?

    Answer- This would be an error/problem with the equipment, specimen, or processing; therefore, it should not be reported by the facility. Some common reasons for a blood test to come back hemolyzed are as follows:[8]

    - The wrong needle was used.
    - The wrong tube was used.
    - The draw happened too slowly.
    - The blood sample was shaken.
    - Patient fist clenching for too long or the tourniquet left on for too long
    - Temperature changes when transporting the sample
    - Processing issues

16. **Question-** Should modifier JZ only be used with single-dose drugs with status indicator K and G?

[8] *Understanding the Hemolyzed Blood Test Results.* Health Research Funding. https://healthresearchfunding.org/understanding-hemolyzed-blood-test-results/

Answer- Yes, modifier JZ, *Zero drug amount discarded/not administered to patient*, must only be used with single-use vials/single-dose packaged drugs with status indicator K (Non-pass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals) or status indicator G (Pass-Through Drugs and Biologicals).

17. **Question-** Does modifier JW apply only to the smallest commercially available single dose vial?

    Answer- CMS requires that the units billed with modifier JW, *Drug amount discarded/not administered to any patient*, should correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate does for the patient to minimize any wastage. There may be exceptions to this requirement during times of drug shortages or other extenuating circumstances.[9]

18. **Question-** Will JZ only be applied if you have administered the whole contents of a single-dose vial of a drug?

    Answer- Yes, modifier JZ, *Zero drug amount discarded/ not administered to any patient*, would only be applied when the entire single-dose vial or package is given to the patient and there is no discarded amount.

19. **Question-** Depending on the circumstances, can reporting modifiers 59 and 76/77 on the same CPT be appropriate? For example, if cardiac catheterization is performed (93458), along with two EKGS on the same DOS (for indications other than the procedure, and therefore reportable). Would the EKGs be reported as 93005-59-76/77?

    Answer- Yes, you could report the EKGs with modifier 59, *Distinct procedural service*, or an X-modifier to show that they were separate and distinct from the cardiac catheterization. You could also append modifier 76, *Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional*, or modifier 77, *Repeat Procedure by Another Physician*

[9] *Billing and Coding: JW and JZ Modifier Billing Guidelines*. CMS National Coverage Policy. Article ID A55932. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=55932

or Other Qualified Health Care Professional, to the second EKG. The first EKG should not have modifier 76 or 77 since it was not a repeated procedure.

20. **Question-** When billing for facility charges at a hospital, do we need to add modifier TC for those CPT codes that have modifier 26?

    Answer- Hospitals are typically exempt from appending modifier TC, *Technical component*, because it is assumed that the hospital is billing for the technical component portion of the onsite service. Private payers should be consulted for specific coding instructions.[10]

[10] *When to Apply Modifiers 26 and TC*. AAPC. https://www.aapc.com/blog/52001-when-to-apply-modifiers-26-and-tc/