

coding corner

correct use of modifiers saves time and money

The use of modifiers is an integral part of coding and claims submission. The correct use of modifiers can eliminate time and expense for both providers and health plans due to claim denials and resubmissions. Using a modifier is a way for you to indicate that the service has been altered by some circumstance(s), but the code description itself has not changed.

FCHP **requires** the use of modifiers when appropriate. Payment can be affected if you don't append the appropriate modifier. The modifiers are reported on the hard copy UB-92 (HCFA-1450) in FL 44 next to the HCPCS code. On the CMS 1500 hard copy, modifiers are reported in Box 24D after the CPT/HCPCS code. There is space for two modifiers.

To determine if a modifier is applicable, begin by asking yourself some questions:

- *Does this procedure have a combination of a technical and professional component?*
Modifiers -26 (professional) and -TC (technical) would be appropriate.
- *Is the procedure specific to an anatomic site?*
Modifiers -RT (right) and -LT (left) would be appropriate.
- *Would using a modifier help to eliminate the appearance of unbundling?*
Modifier -59 would be appropriate. FCHP requires supporting documentation for use of modifier -59.
- *Would using a modifier help eliminate the appearance of duplicate billing?*
Modifiers -76 (repeat by same physician on same day), -77 (repeat by another physician on the same day) and -91 (repeat lab on the same day) would be appropriate. The procedure must be the same procedure. It is listed once and then listed again with the appropriate modifier appended. FCHP may deny payment for services that appear to be duplicate services or procedures.

The modifiers listed in this article are not all inclusive; they represent only a sampling of the total list. Always refer to the current version of CPT/HCPCS for modifiers, their exact descriptions and notes for correct usage.