CPT Modifier Use

5.81. Dr. Raddy, staff radiologist, interprets a chest x-ray that was obtained in the hospital Radiology Department. Dr. Raddy is contracted with the hospital to read radiographs. The equipment and staff are owned and/or employed by the hospital. What modifier, if any, should Dr. Raddy report with the chest x-ray code?

a. No modifier is necessary, since Dr. Raddy interpreted the x-ray under contract with the hospital. The hospital will bill the global and pay Dr. Raddy from the reimbursement.  
   
   *Incorrect answer. Dr. Raddy should report the chest x-ray code with modifier 26, professional component. If he had performed the service with equipment he owned and staff that he employed, he could have reported the global, but since the hospital assumed the technical overhead, he can only report the professional component.*

b. Modifier 26, professional component.  
   
   *Correct answer.*

c. Modifier TC, technical component.  
   
   *Incorrect answer. Dr. Raddy performed the professional component of the split service, not the technical component. He should report modifier 26.*

d. Modifier 59.  
   
   *Incorrect answer. Modifier 26 is the appropriate modifier to report the professional component of a split service. Modifier 59 is reported only when a specific modifier does not exist.*

5.82. Tiny PattiSue Smith, 15 days old, currently weighs 1652 grams. She is taken to the operating room for small bowel resection for necrotizing enterocolitis, a frequent complication of prematurity. The remaining portions of the small bowel were anastomosed end-to-end. CPT code 44120 reports a small bowel resection with anastomosis. Is a modifier necessary, and if so, which modifier?

a. No modifier is needed for the surgery, although the anesthesiologist might need a modifier.  
   
   *Incorrect answer. Modifier 63, procedure performed on infants less than 4 kg should be reported.*

b. Modifier 63 is reported because the baby weighs less than 4 kg and thus is a higher surgical risk than a larger neonate.  
   
   *Correct answer.*

c. No modifier is needed, because code 44120 already applies to neonates who are very low weight.  
   
   *Incorrect answer. Code 44120 is not exempt from the assignment of modifier 63, and this modifier should be assigned.*

d. A modifier is optional, and may or may not be assigned depending upon the departmental coding guidelines.  
   
   *Incorrect answer. Modifier 63, procedure performed on infants less than 4 kg should be reported in this case.*
5.83. A patient is seen in the emergency department because of hyperkalemia due to an inadvertent overdose of his potassium medication. Over the course of the next six hours he receives infusions and his potassium is measured three times. What is the appropriate modifier to report with the second and third potassium determinations?

a. Modifier 59, to show that these were not duplicate charges, but indeed separate incidents.

    Incorrect answer. Modifier 91 is specific for repeat laboratory tests.

b. No modifier is necessary for repeat laboratory tests, only for repeat surgical procedures.

    Incorrect answer. Modifier 91 is specific for repeat laboratory tests.

c. Modifier 91.

    Correct answer.

d. Modifier 91 and 59 should be reported for the second and third determinations.

    Incorrect answer. Only modifier 91 is necessary, as it is specific for repeat laboratory tests.

5.84. A patient who was high on PCP stabbed himself in the chest, causing a pneumothorax. He was seen in the emergency department and Dr. Jones inserted a chest tube. The patient continued under the influence of the PCP and about an hour later, despite soft restraints, managed to free himself and pull out his chest tube. Dr. Jones reinserted the chest tube via a fresh incision. What modifier should be reported on each procedure?

a. Modifier 76, repeat procedure by the same physician, should be reported for each chest tube insertion.

    Incorrect answer. Modifier 76 is the appropriate modifier, but it should be appended only to the second procedure. No modifier is needed on the first procedure.

b. Modifier 76 should be reported with the second procedure, no modifier on the first procedure.

   Correct answer.

c. Modifier 59 should be reported with the second procedure, no modifier on the first procedure.

   Incorrect answer. Modifier 76 is specific for repeat of an identical procedure by the same physician, and should be reported with the second procedure.

d. Either modifier 59 or 76 may be reported on the first and second procedure.

   Incorrect answer. Modifier 76 is specific for repeat of an identical procedure by the same physician, and should be reported with the second procedure. Modifier 59 should be used only when a more specific modifier is not available. No modifier should be reported with the first procedure.
5.85. A patient underwent gallbladder removal by Dr. Pitts on April 1. On April 16, he developed right lower quadrant abdominal pain and evaluation was strongly suggestive of acute appendicitis. Dr. Pitt performed an exploratory laparotomy and appendectomy for an acutely inflamed appendix. What modifier, if any, should be reported with the appendectomy code?

a. No modifier is needed, because the ICD-9-CM diagnosis code and the CPT procedure code clearly identify that this was a procedure not related to the cholecystectomy.

Incorrect answer. Even though the procedure is clearly not related, modifier 79, unrelated procedure or service by the same physician during the postoperative period, should be reported to make the circumstances completely clear to the payer.

b. Modifier 79, unrelated procedure or service by the same physician during the postoperative period, should be reported with the appendectomy code.

Correct answer.

c. Modifier 78, return to the operating room for a related procedure during the postoperative period, should be reported with the appendectomy code.

Incorrect answer. There is nothing to suggest that the acute appendicitis was related to the cholecystectomy. Modifier 79, unrelated procedure or service by the same physician during the postoperative period, should be reported with the appendectomy code.

d. Modifier 58, staged or related procedure or service by the same physician during the postoperative period.

Incorrect answer. This was not a related or stated procedure, but an unrelated procedure for an unrelated diagnosis. Modifier 79, unrelated procedure or service by the same physician during the postoperative period, should be reported with the appendectomy code.
HCPCS Level II Modifiers

5.86. A patient is brought to the emergency department of Community Hospital following a motor vehicle accident. He appears to have an avulsion of the aortic root and is rushed to the operating room where repair is attempted. The patient expires on the operating room table just as the surgery is being completed and before he can be admitted to the hospital. The CPT code for repair of avulsion of the aortic root is designated as an “inpatient only” code under the OPPS. Is there a modifier that the hospital can report to obtain reimbursement for this procedure when performed as an outpatient?

a. No, if an “inpatient only” procedure is performed on an outpatient basis, the hospital cannot obtain reimbursement under any circumstances.

Incorrect answer. Modifier CA may be assigned when a patient expires prior to admission when an “inpatient only” procedure is performed on an emergency basis.

b. Modifier CA, procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission, may be appended to the CPT procedure code.

Correct answer.

c. Modifier ST, related to trauma or injury, may appended and a 50% reimbursement will be available to the hospital.

Incorrect answer. Modifier CA may be assigned when a patient expires prior to admission when an “inpatient only” procedure is performed on an emergency basis.

d. Modifier SC, medically necessary service or supply may be appended and a 25% reimbursement will be available to the hospital.

Incorrect answer. Modifier CA may be assigned when a patient expires prior to admission when an “inpatient only” procedure is performed on an emergency basis.

5.87. A patient undergoes a bunionectomy on the big toe of the right foot. What modifier is appended to report the location of this procedure?

a. No modifier. By definition, bunionectomy is performed on the big toe.

Incorrect answer. Modifier T5, right foot, great toe, is the appropriate modifier.

b. Modifier T5.

Correct answer.

c. Modifier RT.

Incorrect answer. Modifier T5, right foot, great toe, is appropriate, as it is more specific.

d. Modifier TA.

Incorrect answer. Modifier TA reports the left foot, great toe.
5.88. A hospice patient, under hospice care for terminal COPD, falls out of bed and fractures his wrist. He is taken to the emergency department at the local hospital and has cast application for the nondisplaced fracture. What modifier is reported to show that these services are not related to the patient’s hospice-qualifying condition?

a. Modifier GW.
   Correct answer.

b. Modifier AT.
   Incorrect answer. Modifier GW is specific for identifying services not related to a hospice patient’s terminal condition.

c. Modifier GZ
   Incorrect answer. Modifier GW is appropriate for reporting services that are not part of a patient’s terminal condition.

d. Modifier SC
   Incorrect answer. Modifier GW is specific for identifying services not related to a hospice patient’s terminal condition.

5.89. HCPCS Level II modifiers can be used with which of the following code sets?

a. CPT codes
   Incorrect answer. They can be used with both CPT and HCPCS Level II codes.

b. HCPCS Level II codes
   Correct answer.

c. ICD-9-CM volume III codes
   Incorrect answer. They can be used with both CPT and HCPCS Level II codes, but not with ICD-9-CM procedure codes.

d. Both a and b.
   Correct answer.

5.90. Modifiers G1 through G5, which report the levels of URR (Urea Reduction Ratio) in the blood, are reported with codes for ________________, and measure the efficacy of this modality.

a. Laboratory tests
   Incorrect answer. They are reported with dialysis codes.

b. Dialysis codes.
   Correct answer.

c. Coronary artery interventional procedures.
   Incorrect answer. They are reported with dialysis codes.

d. Oxygen therapy.
   Incorrect answer. They are reported with dialysis codes.