

# Claim Modifiers: What Are They and How Do They Affect Me

## Breaking the Code: How CPT<sup>®</sup> Codes and Modifiers Affect Your Costs

Medical care is complicated, and sometimes it can be hard to describe exactly what services you received. So, providers and insurers use a standardized set of codes to help them communicate clearly. These Current Procedural Terminology, or “CPT,” codes are developed and updated by the American Medical Association (AMA), and used by most providers around the country.

There are thousands of CPT codes. Each one represents a specific service, and helps insurers to understand what care was provided. Providers include these codes when they submit claims to your insurer. Then, your insurer generally uses the code to determine how much to pay.

For instance, if your primary care doctor spends 10 minutes examining you, he will use a certain CPT code - in this case, 99201. If he spends 20 minutes examining you, he will use a different code, 99202. Your insurer knows what each of these codes mean. Generally, the longer the visit or more complicated the service, the more your insurer will pay.



### *HCPCS Codes*

Some medical supplies and equipment, like prosthetics and orthotics, don't have CPT codes. Instead, they are assigned a different kind of code called HCPCS (it stands for Healthcare Common Procedure Coding System). You can tell the difference because HCPCS codes start with a letter instead of a number.

### *Modifiers*

What happens if your procedure doesn't fit a specific code? What if it takes more time than usual or your doctor has to run two lab tests instead of one? For those situations, providers add on a two-digit “modifier” to the CPT or HCPCS code. This modifier gives your plan those additional details. Then, your plan may use this information to adjust their payment. Modifiers might also be used for some diagnostic tests, like X-rays, CT scans, or lab services that have two pieces: the service that your doctor provides, and the technical equipment and staff that they use. The modifier “26” is used to describe the professional service. The modifier “TC” is used to describe the technical equipment.

## What Are Some Common Modifiers?

These are some common modifiers you may see on your provider's claim form:

- 22: The procedure was unusually complicated and took more time than the general CPT code allows.
- 51: Your surgeon performed more than one surgical procedure during the same operation.
- 76: Your doctor performed the same procedure more than once during your visit. For example, you may have had multiple X-rays on the same day.
- 91: Your doctor repeated the same diagnostic test, usually on the same day. This might happen if, for example, your first test result is abnormal. Then your doctor might want to re-run the test later in the day.



## Why Does it Matter?

If you go out-of-network, your plan may have certain limits on what it will pay for and modifiers can be used to help identify those limits. For instance:

- Suppose you get two surgeries during the same operation. Some plans may agree to pay 100% of their allowed amount for the first procedure, but only a portion of the allowed amount for the second one. Your plan will know what to pay because your provider will include modifier 51 to indicate you had multiple procedures.
- Suppose you have an X-ray at a hospital instead of a radiology facility. Some health plans may only pay your radiologist the professional portion of the fee (modifier 26), and not the technical portion (modifier TC) – even if the radiologist owns the equipment.

## Modifiers in Action: Some Examples

Let's say you fracture your wrist and need surgery. Then suppose you develop carpal tunnel syndrome, so when your surgeon fixes your wrist, she also performs a carpal tunnel release.

That's two procedures. So, your surgeon will bill for:

- Wrist Fracture repair (CPT Code 25607)
- Carpal Tunnel release (CPT Code 64721, with modifier 51 to show it's a secondary procedure)



### *In-Network*

If you go to an in-network provider, your plan will pay its contracted rate for your first procedure. So, your wrist fracture repair is covered (after you pay your deductible and co-insurance).

Suppose, however, that for the secondary procedures, your plan only pays 50% of the rate. So, it will cover half the contracted rate for the carpal tunnel release. Your network provider has already agreed to accept your plan's payment as payment in full, so you will not have to pay the difference.

### *Out-of-Network*

Let's say your plan pays 80% of its allowed amount for out-of-network procedures. In this case, that means

they will pay 80% of that amount for your wrist fracture repair. But again, for the secondary procedure, your plan only pays 50% of the allowed amount.

Remember, the allowed amount is not necessarily the same as the amount your provider charges. Your provider's charge may be higher, and you could be responsible for the difference.

So in this case, you might owe:

	Wrist fracture repair	Carpal tunnel release
<b>Your surgeon's charge</b>	\$2,000	\$1,000
<b>Your plan's allowed amount</b>	\$1,000	\$600
<b>Your plan pays</b>	80% of \$1,000 = \$800	50% of \$600 = \$300
<b>You pay</b>	\$2,000 - \$800 = <b>\$1,200</b>	\$1,000 - \$300 = <b>\$700</b>

Remember, these are only examples. Your plan's actual provisions may be different. Be sure to check your plan booklet, your insurer's website, or call your insurer so you can be sure you understand how your plan works.

### Your Action Plan: Reading the Code

If you go out of your network for care, it's good practice to take a look at the CPT codes that your provider lists on the bill or claim form. You don't need to be a claims specialist. Just a basic understanding of how these codes work can help you ask the right questions if you need to talk to your provider or insurer.



For instance, if you submit a claim for out-of-network care to your insurer and your out-of-pocket cost seems high:

- Take a look at the CPT or HCPCS code on the claim form or bill.
- Is it five digits long, or seven? If it's seven, that means a modifier has been added.
- Ask your insurer what the modifier is for, and how that changes how much they pay for your service.

A little understanding can also help you resolve errors. Remember, doctors and insurers make mistakes, too. If a modifier was added by accident – for instance, if it indicates you had two lab tests, but you only had one – call your doctor. Ask him or her to correct the error so that you can re-submit the claim to your insurer.

And most importantly – ask questions! Speaking up and asking questions can help clear up confusion about how much you may owe.

FAIR Health does not endorse any products or services.