Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal A-00-07 **Date: FEBRUARY 2000**

CHANGE REQUEST 1079

SUBJECT: Addition of Modifiers 25, 58, 78, and 79 to the List of Modifiers Approved for Hospital Outpatient Use and Correction to Program Memorandum (PM) A-99-41

This PM advises you that effective April 1, 2000, modifiers 25, 58, 78, and 79 will be approved for hospital outpatient use. According to the Current Procedural Terminology (CPT) definition, modifier 25 is defined as a "significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service." Modifier 58 is defined as a "staged or related procedure or service by the same physician during the postoperative period." Modifier 78 is defined as a "return to the operating room for a related procedure during the postoperative period." Modifier 79 is defined as an "unrelated procedure or service by the same physician during the postoperative period."

REVIEW

The use of modifiers is an integral part of the Outpatient Hospital Prospective Payment System (PPS) payment implementation which is scheduled for implementation July 1, 2000.

For your convenience, here is the complete list of modifiers approved for outpatient hospital use and for proper reporting under outpatient PPS. Definitions may be found in the current CPT guide, Appendix A.

Level I (CPT)	Level II (HCPCS/National)		
-25	-LT	-F5	-TA
-50	-RT	-F6	-T1
-52	-E1	-F7	-T2
-58	-E2	-F8	-T3
-59	-E3	-F9	-T4
-73	-E4	-LC	-T5
-74	-FA	-LD	-T6
-76	-F1	-RC	-T7
-77	-F2	-QM	-T8
-78	-F3	-QN	-T9
-79	-F4		
-91			

NOTE: Use of modifiers applies to services/procedures performed on the same calender day.

Other valid modifiers that are used under other payment methods are still valid and should continue to be reported. For example, those that are used to report outpatient rehabilitation and ambulance services. Modifiers may be applied to surgical, radiology, and other diagnostic procedures. Providers must use any applicable modifier where appropriate. Some examples may be found in PM A-99-41, issued September 1999.

CORRECTION

Please note that there was a mistake in PM A-99-41. Section C, third bullet point, Reporting Modifiers on the UB 92 (Form HCFA-1450), stated that with the upcoming claims expansion, up to five modifiers could be placed on the line. On Form HCFA-1450 paper format and the UB-92 flat file version 5.0, as well as the new version 6.0, only **TWO** modifiers can be accommodated. The Medicare implementations 3A.01 and 1A.C1 (COB) of the 837 version 3051 national standard, currently only allows for **TWO** modifiers as well. Please disregard language allowing five modifiers.

The *effective date* for this PM is April 1, 2000.

The *implementation date* for this PM is April 1, 2000.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2001.

If you have any questions, contact Sarah Shirey via e-mail: SSHIREY@HCFA.GOV