Modifiers

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This section provides information about commonly used modifiers. For a complete list of modifiers, refer to the *Modifiers: List* section in this manual.

Inappropriate use of a modifier or using a modifier when it is not necessary will result in denial or a delay in claim payment. Some CPT® codes, by nature of their description, are for the professional or technical component only. In these cases, a modifier will make the claim suspend unnecessarily.

Place of Service and Payment Percentages Exception Modifiers

Certain medical/surgical procedures normally performed in an office setting are reimbursable at 80 percent of the Medi-Cal allowance when provided in a licensed surgical clinic, hospital outpatient department or emergency room. Modifier 22 in combination with modifier SC (medically necessary service/supply) (both modifiers are required) or modifier 22 in combination with modifiers SC and ET (emergency services) (all three modifiers are required) can be used to identify conditions under which the physician or podiatrist services may qualify for 100 percent Medi-Cal allowances. When billing for the exception to 80 percent reimbursement, modifier 22 must be the first modifier on both the *Treatment Authorization Request* (TAR) and the claim form for the claims to reimburse correctly.

Modifiers 22/SC

The following policy applies only to community hospital outpatient departments, county hospital outpatient departments and surgical clinics.

Modifiers 22/SC:

Enter this combination of modifiers when the patient's age, size of lesion, tendency to bleed or other potential complication dictates treatment in a licensed surgical clinic, (see following Note) hospital outpatient department or emergency facility.

When modifiers 22/SC are entered as part of a medical/surgical procedure code, explain the reason in the *Remarks* field (Box 80)/*Additional Claim Information field* (Box 19) of the claim or on an attachment.

Note: When a medical (as opposed to surgical) procedure is performed in a licensed surgical clinic, do not enter modifiers 22/SC. Medical procedures rendered in a surgical clinic are not subject to reimbursement at 80 percent. These procedures will be reimbursed up to 100 percent of the Medi-Cal allowed amount when billed by a surgical clinic on the *UB-04* claim.

Modifier 99

Modifier 99 (multiple modifiers) is entered on a claim line before any other modifier to accommodate the claims processing system. The multiple modifiers used must be explained in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or on an attachment.

Modifier 99 Disallowed

Claims will deny if modifier 99 is submitted for the following circumstances:

When billing for non-emergency medical transportation. When billing split-billable claims with no modifier (professional and technical service component) or with modifier 26 (professional component) and TC (technical component). When provider manual policy indicates modifier 99 is disallowed.

‹‹JW Modifier

JW modifier (drug amount discarded/not administered to any patient) is a HCPCS Level II modifier used on a drug claim to report the amount of drug or biological that is discarded and eligible for payment under the discarded drug policy.

Eligible drug wastage or discarded drugs and biologicals may be reimbursable if documented using the JW modifier. JW can only be applied to the amount of drug or biological that is discarded.

The discarded drug amount is the amount of a single-use vial or other single-use package that remains after administering a dose/quantity of the drug to a Medi-Cal beneficiary. The drug may be reimbursable for the amount of drug that has been discarded, up to the amount that is indicated on the vial or package label. The amount billed as wastage using JW modifier must not be administered to another patient or billed again.

The expectation is that the JW modifier will be used mostly in the physician's office and hospital outpatient settings for beneficiaries who receive drugs incident to physicians' services.

This policy applies to all separately billable drugs that are designated as single-use or single-dose on the FDA-approved label or package insert.››

‹‹JW modifier should not be used for the following:

- Drugs that are not separately payable, such as packaged Outpatient Prospective Payment System (OPPS) drugs or drugs administered in the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) setting since they are not generally separately billable
- Drugs paid under the Part B drug Competitive Acquisition Program (CAP) (the CAP remains on hold and there is currently no list of CAP medications)
- Claims for hospital inpatient admissions that are billed under the Inpatient Prospective Payment System (IPPS)
- When the actual dose administered is less than the HCPCS billing unit, as payment will not be made using fractional billing units and this may result in overpayment

Billing, Claims and Documentation

1. When submitting claims for drugs and biologicals, providers must bill drug wastage using the JW modifier in addition to the name, dosage, route of administration and National Drug Code (NDC) of the drug or biological.
2. Providers must clearly document the amount of discarded drugs or biologicals in the Medi-Cal beneficiary's medical record, including the date, time and the quantity wasted.
3. JW modifier is only applicable to the amount of the drug or biological that is wasted.
4. The modifier shall only be used for drugs in single-dose or single-use packaging.
   - The use of JW modifier will not be reimbursed for drugs that are from multiple dose vials or packages. Package inserts are available for verification of package size designation on the FDA website at http://www.accessdata.fda.gov/scripts/cder/drugsatfda/.
5. Providers must bill the discarded drug or biological on a separate claim line with JW modifier. The unit field should reflect the amount of drug discarded (see the example below for additional details).››

‹‹JW Modifier Billing Example

Billing Example Using JW Modifier

Claim Line 1 – Administered	Claims Line 2 – Wastage
• HCPCS code • No modifier • Number of units administered • Calculated submitted price for only the amount of drug administered	• HCPCS code • JW modifier • Number of units wasted • Calculated submitted price for only the amount of drug wasted

Example:

- If a single-use vial is labeled to contain 200 mg/5ml and the long descriptor of the HCPCS code of the drug indicates one (1) HCPCS billing unit = 20 mg.
- 180 mg dose (9 billing units) was administered to the patient and 20 mg (1 billing unit) was wasted, 9 units would be billed on the first line and 1 unit would be billed on the second line with a JW modifier
- Both lines would be processed for payment
- Providers must document the amount given and the amount wasted of the drug or biological in the Medi-Cal beneficiaries' medical records

Billing Example in Which JW Modifier is Not Permitted

Providers must not bill with JW modifier when the actual dose of the drug or biological administered is less than the HCPCS billing unit.

Example:

- One billing unit is equal to 20 mg of the drug in a single use vial
- 16 mg dose was administered to the patient while 4 mg of the drug was discarded
- 16 mg dose is billed using one billing unit representing 20 mg on a single line item
- Single line item of one (1) unit would be processed for payment of 20 mg of drug administered and discarded
- Billing another unit on a separate line item with JW modifier for the discarded 4 mg of drug would result in overpayment and is therefore not permitted
- Providers must document the amount given and the amount wasted of the drug or biological in the Medi-Cal beneficiaries' medical records››

Radiology/Pathology

Radiology and pathology CPT codes 70000 through 79999 and 80000 through 89999, and pathology HCPCS codes S3620 and Z2010 may require one of the modifiers listed below. A claim failing to have a modifier, if required for these procedures, will be denied.

For those services that are split-billable, providers are required to use one of the following modifiers to receive the approved reimbursement rate for radiology or pathology services regardless of Place of Service:

Modifiers for Split-Billable Radiology or Pathology Services

Modifier	Description
26	Only the professional component (reading and report) was performed by the billing provider
TC	Only the technical component (tracing) was performed by the billing provider
QW	CLIA waived tests; indicates that the provider is performing testing for the procedure with the use of a specific test kit from manufacturers identified by the Centers for Medicare & Medicaid Services (CMS)
P1, ZE or ZG	Used for anesthesia reimbursement when essential to performance of a radiology or pathology procedure
90	Used when performed by an outside laboratory but billed by another provider. Only specified providers may use this modifier. Refer to the *Pathology* section in the appropriate Part 2 manual.
99	Used when two or more modifiers are necessary to completely delineate a service; the multiple modifiers used must be explained in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or on an attachment.

Note: When billing for both the professional and technical service components, a modifier is neither required nor allowed. See the *Pathology* and *Radiology* sections in the appropriate Part 2 manual for policy regarding radiology codes.

Vestibular Function Tests and Non-Invasive Vascular Diagnostic Studies (NVDS)

Providers must use split-billing modifiers when billing codes for vestibular function tests or Non-invasive Vascular Diagnostic Studies (NVDS).

Electroencephalogram

CPT codes 95812 through 95826 must be billed with split-billing modifiers indicating the service actually performed. A claim failing to have a modifier for these CPT codes will be denied.

Fetal Stress/Non-Stress Testing

CPT codes 59020 (fetal contraction stress test), 59025 (fetal non-stress test) and 76819 (fetal biophysical profile, without non-stress testing) are split-billable codes. When billing for both the professional and technical service components, a modifier is neither required nor allowed. When billing for only the professional component, use modifier 26. When billing for only the technical component, use modifier TC. These codes may not be billed with modifier -51 (multiple procedures) or with any other modifier.

Claim Completion

When entering modifiers on a claim, do not include hyphens.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.