Outpatient Facility Coding Alert

Modifier 101: Refresh Your Memory on Modifier Intent

Don't miss when you shouldn't report RT, LT, or 50.

A modifier gives clarity to the code used for billing. It is a numeric or an alpha numeric code added at end of the procedure code. Modifiers can help to change the description of the services without changing the procedure code itself. It provides specificity by adding the additional information, for example anatomical site. They also help in eliminating duplicate billing and unbundling.

In appropriate situations use the correct modifiers with the following codes:

- Surgical procedure (codes 10000-69999)
- Radiology (codes 70010□79999)
- Diagnostic procedures (codes 90700□99199).

Not all codes need modifiers to explain special circumstances.

- If a narrative definition indicates multiple occurrences, then do not use modifiers RT, LT, or 50 to indicate anatomical site location on body. For example, code 11056 (Paring or cutting of benign hyperkeratotic lesion [eg, corn or callus]; 2 to 4 lesions) indicates multiple lesions.
- Likewise, if the narrative definition of a code indicates the procedure applies to more than two sites, then do not report with modifiers RT, LT, or 50. For example, code 11600 (Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.5 cm or less) indicates different body sites so no modifier to explain anatomic location is necessary.