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Pain Management Coding Alert

Modifiers: Ensure Your Portion of Pay with Modifier 26

Here's when you might need this modifier.

When a medical provider performs services using another facility's equipment, the practice must be able to decide whether to include modifier 26 (Professional component) on the claim.

In most cases where your provider performs a service with equipment your practice doesn't own, you'll need to include modifier 26 to show that you are only coding for your physician's service.

Outcome: When you report modifier 26, the payer "reduces payment to just the physician's work, not the cost of the equipment," explains **Kelly D. Dennis, ACS-AN, CANPC, CHCA, CPC, CPC-I**, owner of Perfect Office Solutions in Leesburg, Fla. While using modifier 26 correctly will reduce your pay, it'll also mean you've coded correctly which should be the main concern of every medical practice.

When do you need to include modifier 26 on a claim? Read on to find out.

'Professional Services' Could Equal 26 Opportunity

Coders employ modifier 26 most commonly in "office or outpatient facilities when the equipment is the property of the clinic or facility, and not [your] physician," explains **Suzan (Berman) Hauptman, MPM, CPC, CEMC, CEDC**, medical coding director at Acusis in Pittsburgh, Pa.

Often, a CPT® code's relative value units (RVUs) are broken down into a technical component and a professional component; you'll append modifier 26 when your physician only provides the professional component of one of these codes, confirms **Barbara J. Cobuzzi, MBA, CPC, CENTC, COC, CPC-P, CPC-I, CPCO**, vice president at Stark Coding & Consulting, LLC, in Shrewsbury, N.J.

If you don't use modifier 26 when appropriate, you'll open your practice up to accusations of overcoding and all sorts of potential red tape.

You Might Use 26 More Often in These Settings

There is no definitive list of the places of services a modifier 26 claim might occur. The following locations are far more likely to see many modifier 26 claims, confirms **Yvonne Bouvier, CPC, CEDC**, senior coding analyst for Bill Dunbar and Associates, LLC, in Indianapolis, Ind.:

- hospital operating rooms (ORs),
- hospital emergency departments (EDs),
- laboratories,
- hospices,
- radiology clinics, and
- ambulatory surgery centers (ASCs).

One common modifier 26 scenario is electroencephalogram (EEG). Let's say your physician performs an extended monitoring EEG. Total encounter time is 47 minutes. Unless your physician owns the EEG equipment, you'd report 95812 (Electroencephalogram [EEG] extended monitoring; 41-60 minutes) for the EEG with modifier 26 appended.

EEG, EMG Among Frequent Modifier 26 Targets

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In addition to 95812, some of the services your physician might provide that could be modifier 26 moments include:

- 95813, ... greater than 1 hour
- 95816, Electroencephalogram (EEG); including recording awake and drowsy
- 95819, ... including recording awake and asleep
- 95822, ... recording in coma or sleep only
- 95824, ... cerebral death evaluation only
- 95827, ... all night recording
- 95860, Needle electromyography; 1 extremity with or without related paraspinal areas
- 95861, ... 2 extremities with or without related paraspinal areas
- 95863, ... 3 extremities with or without related paraspinal areas
- 95864, ... 4 extremities with or without related paraspinal areas
- 95907, Nerve conduction studies; 1-2 studies through 95913, ... 13 or more studies.

Remember: This is not an inclusive list of codes that could be coded with modifier 26; it's just representative of some of the procedures your physician might perform using a facility's equipment. Also, some practices will have the equipment necessary on-site for some of the potential modifier 26 codes; many physicians perform EMGs in the office, for example. So be sure that the physician used equipment owned by another facility before appending modifier 26. Otherwise, you'll be leaving money on the table, as modifier 26 reduces your reimbursement by half.

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