

## MODIFIERS - CPT

The CPT system contains thirty-one modifiers. Modifiers -50 (bilateral), -52 (when used to indicate a discontinued procedure), -53, -73, and -74 apply only to surgical procedures. General guidelines for using modifiers appear in the form of questions to be considered. If the answer to any of the following is yes, then it is appropriate to use the applicable modifier.

- Will the modifier add more information regarding the anatomic site of the procedure?
- Will the modifier help to eliminate the appearance of duplicate billing?
- Would a modifier help to eliminate the appearance of unbundling?

All modifiers are listed in Appendix A of CPT. CPT modifiers and their definitions are explained below.

### -21 Prolonged Evaluation and Management Services

This modifier reports services that take more time or are greater than the highest level E/M code in a particular category. This modifier is used with codes such as 99205, 99215, 99223, 99233, 99245, 99255, etc.

### -22 Unusual Services

The *Unusual Services* modifier has conceptually distinct uses in CPT. Its primary purpose is to denote circumstances for which a procedure or service required an "unusual" amount of time or effort to perform. As such, a higher fee is charged. A word of caution regarding the use of the unusual service modifier -- its use implies that the procedure or service was distinctly more time-consuming or difficult to perform. When using the modifier you must also send a special report to the insurance carrier that describes the unusual nature of the service and justifies the additional charge. Even when justified, it may be difficult at best to obtain higher than normal reimbursement from the majority of payers.

Consider a surgical procedure that typically requires one to two hours to perform. Reimbursement from payers will be the same whether the procedure takes one or two hours. Why? Reimbursement averages out across patients over time. The use of the unusual services modifier would be inappropriate if the procedure took two hours, just as use of the reduced service modifier would not be appropriate if the procedure took one hour.

However, use of the unusual services modifier would be more appropriate with the above hypothetical surgery if the operation was very difficult and required three hours to perform because the patient was obese.

The -22 modifier has other specific uses in CPT

For example, in the Psychiatry section, the unusual services modifier is sometimes used to communicate that the patient was seen for a period greater than is customary.

### -23 Unusual Anesthesia

Under some circumstances general anesthesia is given when normally either a local or no anesthesia is provided.

For example, performing a cystoscopy on a three-year-old child would likely require a general anesthesia, whereas the same procedure on an adult would not. Thus, use of a general anesthetic when performing a cystoscopy is an example of unusual anesthesia.

Insurance companies will want to know why the anesthesia was required. Therefore, when submitting the unusual anesthesia modifier be sure to include a report that focuses on the circumstances which required that the patient receive a general anesthetic. The use of this modifier is generally restricted to anesthesiologists.

**-24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period**

This modifier allows the physician to report that a service was performed during a postoperative or global period for a reason(s) unrelated to the original procedure. Modifier –24 should be billed with an E/M code. Do not use this modifier with a surgical code. The diagnosis code used must support the service.

For example, a patient who is being followed by her gynecologist during a pregnancy comes in for an additional visit because she has developed acute bronchitis. The bronchitis is unrelated to the pregnancy and necessitated an additional visit over and above her regular pregnancy check-ups. The E/M code for the visit is billed to the insurance carrier with a –24 modifier and the diagnosis code used is 466.0 for Acute Bronchitis.

**-25 Significant Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service**

This modifier indicates that on a day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. Assign the proper E/M code and amount as appropriate for the service rendered.

The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding the modifier –25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery.

Modifier –25 should be appended only to E&M service codes within the range of 92002-92014, 99201-99499, and with HCPCS codes G0101 and G0175

**-26 Professional Components**

Many listed procedures consist of both technical and professional components. Technical components include such things as equipment, technician time, and supplies that are used in the performance of a procedure. The professional component refers to the physician's time, skill, and judgment in interpreting the results of tests and procedures.

For example, consider the simple chest X-ray described in code 71010. If the radiograph of the patient's chest is taken in the physician's office utilizing both the physician's equipment and staff, the charge for the chest X-ray will include the use of the equipment, film, chemicals, and staff time as well as the physician's time to interpret the X-ray itself. As such, the charge for code 71010 will include both the technical and professional components.

In contrast to the above example, suppose that the physician does not have X-ray equipment, and refers the patient to a local hospital where the "picture" will be taken. The hospital, in turn, sends the X-ray to a radiologist who interprets the chest X-ray. The radiologist would bill the patient for interpreting the radiograph only and use the "-26" professional component modifier as shown below.

71010-26 Interpretation, single view chest X-ray

By the use of this modifier, the radiologist can restrict his or her charge to the professional component -- the interpretation.

**-27 Multiple Outpatient Hospital E/M Encounters on the Same Date**

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E&M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding the modifier -27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital settings(s).

Modifier -27 should be appended only to E/M service codes within the range of 92002-92014, 99201-99499, and with HCPCS coded G0101 and G0175.

**-32 Mandated Services**

Mandated services are those requested by an insurance carrier, peer review organization, utilization review panel, HMO, PPO or other entity. Typically, the request is for a second or third opinion regarding a patient's illness or treatment. When mandated services are requested, the physician performing the service is usually required to accept assignment from the payer, and in turn, the payer reimburses the doctor 100 percent of the payer's allowable for the service.

An example of a mandated service would be an extended additional opinion consultation. This would be reported as: 99274-32

The -32 modifier is used to alert the payer's claim processors that the service was mandated and should receive special handling.

**-47 Anesthesia by Surgeon**

When the surgeon is required to provide the general anesthesia services normally handled by an anesthesiologist, the circumstance should be noted by adding the -47 or 09947 modifier to the surgery code(s). This modifier is often used by surgeons working in rural areas where the services of anesthesiologists or nurse anesthetists are not always available. To report the modifier, list the surgery code(s) a second time, and place the modifier on the second code.

For example, suppose the surgeon removed a ruptured appendix from a patient and also provided a general anesthetic. The surgeon would code as follows:

44960	Appendectomy, ruptured appendix
44960-47	Anesthesia for appendectomy

Listing separate charges for each of the services would be appropriate.

**-50 Bilateral Procedures**

The bilateral modifier is restricted to surgical procedures only (CPT codes 10040 – 69990). It is not required for radiology procedure codes or diagnostic procedure codes.

Procedures are now assumed to be unilateral unless they are either always performed bilaterally or are otherwise noted in CPT. The most commonly accepted method of reporting bilateral procedures is to list the procedure twice and add the "-50" modifier to the second procedure.

For example, Otoplasty is performed on a patient's left and right ears:  
69300-RT Otoplasty, protruding ear RIGHT  
69300-50-LT Otoplasty, protruding ear LEFT

Note that the words "right" and "left" have been added to clarify that the procedures were indeed performed bilaterally. Also, it is common for physicians to report their full charge for each procedure and let the payer reduce the amount on the second, or bilateral, procedure.

Some payers accept an alternative method of billing bilateral procedures. This method involves listing the procedure once and adding the "-50" modifier as shown below:

69300-50 Otoplasty, protruding ear, bilateral

If this method is used, place a "2" in the UNITS column of the claim form so that the payer is aware that two procedures were performed. The charge reported on the claim for the procedures is typically twice that of what the physician charges for performing one of the procedures.

Bilateral procedures are identical procedures (i.e., you use the same CPT code) performed on the same anatomic site but on opposite sides of the body. Furthermore, in most instances, each procedure must be performed through its own separate incision to qualify for bilateral.

Note: Modifier –50 does not apply to radiology procedures.

**-51 Multiple Procedures**

This modifier has traditionally been used to identify multiple surgical procedures performed on a patient during the same operative session. It is applicable when unrelated procedures are performed during the same operative session or when multiple related procedures are performed and there is no single inclusive code available. List the major procedure or service (most revenue intensive) first on the HCFA-1500 claim form, then attach modifier –51 to each applicable secondary procedure code.

For example, the repair of a simple neck wound and the closed treatment of a clavicle fracture would be coded as:

23500 Treatment closed clavicle fracture without manipulation  
12005-51 Simple closure neck wound

Note that the higher charge procedure (fracture treatment in this case) is listed first and the multiple procedure modifier is added to the lesser or secondary service. If three procedures had been performed, the services would be ranked from highest to lowest charge on the claim form and the "-51" modifier would be added to all but the first (highest charge) procedure.

**-52 Reduced Service**

Just as the unusual services modifier (-22) is used to denote abnormally difficult or time-consuming procedures, the reduced service modifier -52 or 09952 signifies the opposite: that a procedure was reduced or eliminated in part.

For example, consider the physician who removes a coccygeal pressure ulcer and performs a coccygectomy but does not use a primary suture or skin flap closure. (The physician wants to continue cleansing the wound for a period of time before closing.) The proper way to report the procedure would be:

15920-52

At a later date the physician would code for the appropriate wound closure procedure.

Many coders mistakenly use the "-52" modifier to reduce a charge for a patient who is indigent. The physician performed the procedure or service as described, but did not want to charge the patient the full amount. The "-52" modifier should NOT be used for this purpose.

**Effective January 1, 1999, a new modifier -73 replaces modifier -52 for reporting discontinued services. Modifier -52 still applies to radiology services for "reduced" but not terminated procedures.**

**-53 Discontinued Procedure**

This modifier indicates that the physician elected to terminate a surgical or diagnostic procedure. A surgical procedure may have been started, but because of extenuation or threatening circumstances was discontinued. Modifier -53 is not used to report elective cancellation of a procedure prior to the anesthesia induction and/or surgical preparation in the operating suite.

**Effective January 1, 1999, a new modifier -74 replaces modifier -53 for reporting these discontinued services. Modifier -53 will not longer be an acceptable modifier for hospital reporting to include radiology procedures.**

**-54 Surgical Care Only**

When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified.

**-55 Postoperative Management Only**

When one physician performs the postoperative care and evaluation and another physician performs the surgical procedure, the postoperative component may be identified by adding the modifier '-55' to the usual procedure number.

**-56 Preoperative Management Only**

When only one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by addition the modifier '-56' to the usual procedure number.

**-57 Decision for Surgery**

Modifier –57 identifies an evaluation and management service that results in the initial decision to perform surgery. Even though modifier –57 is included in the guidelines for evaluation and management, surgery, and medicine services, it should only be reported with E/M codes. It is to be used in circumstances where a major surgery is performed within less than 24 hours of the initial evaluation.

Medicare has said that practices should use –57 only with major surgical procedures. These are defined as procedures having a preoperative period one-day before the surgery and 90 days afterward in the postoperative period. Many commercial carriers have also adopted this ruling.

Example: A patient presents to the emergency department complaining of acute lower abdominal pain. She is evaluated by a general surgeon who determines that she has a ruptured appendix. He immediately transfers her to the operating suite and performs an appendectomy. The services would be coded as follows:

99284-57	Emergency room E/M service
44960	Appendectomy for ruptured appendix

**-58 Staged or Related Procedure or Service by the Same Physician during the Postoperative Period**

There are three ways to use modifier –58:

1. For a surgery result planned in stages – a staged procedure

Example: 54308-58 would be used for “urethroplasty for second stage hypospadias repair; less than 3 cm” if this second stage was performed during the postoperative period of the first procedure.

2. To report a more extensive procedure performed during the postoperative period of a less extensive procedure.

Example: 54352-58 would be used for “repair of hypospadias cripple requiring extensive dissection” if the procedure was performed during the postoperative period of 54308 above.

3. To report a therapy given after a diagnostic surgical procedure

Example: 29870 “diagnostic knee arthroscopy”, carries a 90-day global period. If a claim is reported under the same surgeon’s name for physical therapy during the 90-day postoperative period, 97124-58 should be reported for the massage therapy.

**-59 Distinct Procedural Service**

Modifier –59 allows the physician to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier –59 is appropriate for procedures or services that are not normally reported together, but are appropriate under the circumstances. CPT states that modifier –59 may represent a different session or patient encounter, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same date by the same physician.

Example: On Monday, a dermatologist performs a biopsy on the face. On Thursday, following the results of the biopsy, he removes the 2 cm malignant lesion and does another biopsy of a different site on the face. The services performed on Thursday are reported as follows:

11642	Excision malignant lesion, face
11100-59	Biopsy

## 62 Two Surgeons

This modifier has two distinct uses.

First, it is reported when two physicians are acting as co-surgeons. That is, each surgeon is acting as a "primary" surgeon performing a different aspect of a complex procedure.

Example: a laminectomy is performed jointly by a neurosurgeon and an orthopedic surgeon. Each physician might list the following on his/her claim:

63045-62 Laminectomy, cervical

Third party payers often allow sixty percent of their prevailing to each surgeon in such cases.

Second, the two surgeons modifier may be used when two primary surgeons, usually in different specialties, perform different procedures on a patient during the same operative session.

Example: a general surgeon performs a windpipe incision on a trauma patient while another surgeon works to stop the patient's bleeding. Each surgeon could list his/her CPT code(s) with the addition of the "-62" modifier thus denoting that the services were performed during the same operative session.

Note that in the first example, each surgeon reported the same CPT code. Use of the two surgeons modifier is important in such circumstances: it helps ensure that the payer understands that two surgeons were involved in performing the procedure and that double billing is not taking place. In the second example, each surgeon reported different CPT codes. Use of the two surgeons modifier is not as important in this situation.

Due to increasing third party payment restrictions, it may be helpful to send a special report (KISS letter) with the claim that explains and justifies the need for two Primary surgeons. Some payers may assume that the procedure(s) can be performed by a primary surgeon and an assistant rather than by two primary surgeons.

## -66 Surgical Team

Certain complex surgical procedures require the skills of more than two surgeons. A good example is the surgical team that implants an artificial heart. As with the "62" modifier, the physicians performing the surgery usually have different skills or specialties. Each member of the team would add the -66 or 09966 modifier to the procedures he/she performed as part of the surgical team.

As with the two surgeons situation, it may be necessary to communicate the need for the team of surgeons to the insurance company. This is especially true in cases where the need for the team may not be immediately obvious to the claims processor.

**-73 Discontinued Out-Patient Hospital/Ambulatory Surgery Center Procedure Prior to the Administration of Anesthesia**

Due to extenuating circumstances or those that threaten the well being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but canceled can be reported by its usual CPT procedure code with the addition of this modifier.

**-74 Discontinued Out-Patient Hospital/Ambulatory Surgery Center Procedure after Administration of Anesthesia**

Due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia or after the procedure was started (incision made, intubation started, scope inserted, etc).

The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier -53.

**-76 Repeat Procedure By Same Physician**

**-77 Repeat Procedure By Another Physician**

These two modifiers are to be used when the procedure has been repeated subsequent to the original service. You need to submit these modifiers because, without them, the insurance company may think you accidentally double billed for the service.

Example: A patient is brought to the hospital with internal hemorrhaging that is repaired surgically. Three days after surgery, the patient begins hemorrhaging again and the surgeon must perform the same repair again. Would you use the repeat procedure modifier on the second repair? Yes, assuming that the same procedure code was being reported. If a different physician had performed the second repair, he/she would use the 77 modifier.

It may be necessary to send a special report with the claim explaining why the procedure needed to be repeated. This is appropriate in cases where the need for the repeat may not be clear to the carrier.

**-78 Return to the Operating Room for a Related Procedure during the Postoperative Period**

Modifier -78 reports related procedures performed in the operating room within the assigned postoperative period of a surgical. This modifier is often utilized when the patient develops a complication that requires a return trip to the operating room for intervention.

Example: A patient's operative site bleeds after an initial surgery and requires a return to the operating room to stop the bleeding, the same procedure is not repeated. Thus a different code, 35860, exploration for postoperative hemorrhage, thrombosis or infection; extremity, would be reported with the -78 modifier appended. Since the same procedure is not repeated, modifier -76 would not be appropriate to use.

**-79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period**

Modifier –79 notifies payers that the procedure was performed during the postoperative period of another procedure but is *not* related to that surgery. The diagnostic codes must document medical necessity of the service, so the ICD-9-CM codes are usually different for this service from those reported with the initial procedure.

Example: A patient has a femoral-popliteal graft (35556) and goes home. The incision and graft heal well. However, the patient develops acute renal failure a week after being home and is hospitalized. The patient does not respond to medical treatment of the renal failure. Hemodialysis is indicated, and a second physician inserts a cannula for hemodialysis (36810).

The services of the second surgeon are reported as 36810-79 because this service is unrelated to the femoral-popliteal bypass graft performed during the previous hospitalization.

If the –79 modifier is not appended to this procedure, the third-party payer may not know that this service is not related to the femoral-popliteal graft (i.e., the computer program used by the third-party payer may not be able to distinguish that this service is not related to the previous surgery and may automatically reject this claim).

Providing documentation to indicate the service is unrelated to the first procedure may be helpful compared to clearing up a problem retrospectively.

**-80 Assistant Surgeon**

One physician assists another physician in performing a procedure. If an assistant surgeon assists a primary surgeon and is present for the entire operation, or a substantial portion of the operation, then the assisting physician reports the same surgical procedure as the operating surgeon. The operating surgeon does not append a modifier to the procedure that he/she reports. The assistant surgeon reports the same CPT code as the operation physician, with modifier –80 appended.

Example: To report a closure of intestinal cutaneous fistula, the primary operating surgeon reports code 44640, and the assistant surgeon reports 44640-80. The individual operative report submitted by each surgeon should indicate the distinct service provided by each surgeon.

**-81 Minimum Assistant Surgeon**

At times, while a primary operating physician may plan to perform a surgical procedure alone, during an operation circumstances may arise that require the services of an assistant surgeon for a relatively short time. In this instance, the second surgeon provides minimal assistance, for which he/she reports the surgical procedure code with the –81 modifier appended.

**-82 Assistant Surgeon (Where Qualified Resident Not Available)**

The prerequisite for using the -82 modifier is the unavailability of a qualified resident surgeon. In certain programs (e.g., teaching hospitals), the physician acting as the assistant surgeon is usually a qualified resident surgeon. However, there may be times (e.g., during rotational changes) when a qualified resident surgeon is not available and another surgeon assists in the operation. In these instances, report the services of the nonresident-assistant surgeon with the -82 modifier appended to the appropriate code. This indicates another surgeon is assisting the operating surgeon instead of a qualified resident surgeon.

**-90 Reference (Outside) Laboratory**

When the physician bills the patient for lab work that was performed by an outside (or "reference") lab, add the -90 or 09990 modifier to the lab procedure codes. Physicians should never bill Medicare or Medicaid patients for lab work done outside their office.

Example: An internist performs an examination of a patient and, as part of the exam, orders a complete blood count. He does not perform in-office lab testing. He has an arrangement with a laboratory to bill him for the testing procedure, and, in turn, he bills the patient. The physician's staff performs the venipuncture. The physician reports the appropriate E/M code, the venipuncture (36415), and 85024-90 for the CBC performed by the outside lab.

**-91 Repeat Clinical Diagnostic Laboratory Test**

May be appended to a laboratory test code to indicate that a laboratory test was performed multiple times on the same day, for the same patient, and that it was necessary to obtain multiple results in the course of treatment. Modifier -91 is not intended to be used when laboratory tests are rerun to confirm initial results due to testing problems encountered with specimens or equipment; or for any other reason when a normal, one-time, reportable results is all that is required. Modifier -91 may not be used when there are other code(s) to describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing).

**-99 Multiple Modifiers**

If two or more different modifiers are added to the same procedure, a third modifier, the -99 or 09999 can be added to alert the carrier to the fact that two or more modifiers are associated with the procedure.

For example, to report for the physician who assisted on a bilateral subcutaneous mastectomy (19182) you would code as shown below. Since the procedure is bilateral, you must list each procedure separately. In this case, each procedure will list the assistant surgeon modifier (-82), and the second, bilateral procedure requires the use of the -50 modifier. Since there are two modifiers on the second procedure, the -99 modifier is listed.

19182-82 (for the first procedure)  
19182-99 (-99 for multiple modifiers on second procedure)  
or  
19182-50/82

Most carriers require that you have a charge for each line used on the claim form. Thus, you may want to string the modifiers together on the same line on the claim form. You can do this by putting the -99 modifier next to the code in the procedure column and listing the other modifiers in the procedure description column.