Common CPT‡ Code Modifiers

This guide provides information on common CPT‡ code modifiers. In addition, Abbott offers a reimbursement hotline, which provides live coding and billing information from dedicated reimbursement specialists. Hotline support is available from 8 a.m. to 5 p.m. Central Time, Monday through Friday at (855) 569 6430. Hotline reimbursement assistance is provided subject to the disclaimers set forth in this guide.

MODIFIER	DESCRIPTION
22	**Increased Procedural Services:** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service. It should only be reported with procedure codes that have a global period of 0, 10, or 90 days.
25	**Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service:** It may be necessary to indicate that on the 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 other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M servicemay 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 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. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.
51	**Multiple Procedures:** When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes.

MODIFIER	DESCRIPTION
52	**Reduced Services:** Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. Modifier 52 is used for "unusual (reduced) circumstances." It designates that the service performed was significantly less than usually required. In many instances, attachments, medical records, et. Are not required to be sent in if an explanation for the reduction is in the narrative field of the claim. For example, submit "one-view only" in the narrative when only one view of a two-view study is performed. Similarly, "right side only" may be submitted when a procedure code that is bilateral by definition is not performed bilaterally. When additional information to support the use of the 52 modifier cannot be contained in the narrative of the claim, additional documentation may be submitted.
53	**Discontinued Procedure:** Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgerycenter (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).
59	**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

MODIFIER	DESCRIPTION
62	**Two Surgeons:** When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added.
73	**Discontinued Outpatient Hospital/Ambulatory Surgical Center (ASC) 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 cancelled can be reported by its usual procedure number and the addition of the modifier 73. Note: 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. Physicians should not use this modifier. This is only appropriate for use by the ASC.
74	**Discontinued Outpatient Hospital/Ambulatory Surgical Center (ASC) Procedure After 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, after the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the procedure started but terminated can be reported by is usual procedure number and the addition of the modifier 74. Note: 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. Physicians should not use this modifier. This is only appropriate for use by the ASC.
76	**Repeat Procedure or Service by Same Physician:** It maybe necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: Do not report this modifier with 'add-on' codes denoted in CPT‡ with a "+" sign. If a service defined as an 'add-on' code is repeated or provided more than once (based on description) on the same day by the same provider, report the 'add-on' code on the one line with a multiplier in the unit field to indicate how many times that service was performed. For example, CPT‡ 64636 (each additional facet joint) (billed in addition to primary/principle code 64635) is reported on one line as: 64636, units equal 3 (or the total number of additional facet joints (not bilateral) in addition to the initial/single facet joint billed under CPT‡ code 64635). In this example follow CPT‡ instruction if provided bilaterally.
77	**Repeat Procedure by Another Physician:** The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure or service.

MODIFIER	DESCRIPTION
78	**Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period:** It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)
79	**Unrelated Procedure or Service by the Same Physician or Qualified Health Care Professional During the Postoperative Period:** The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)
80	**Assistant Surgeon:** Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).
81	**Minimum Assistant Surgeon:** Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure numbers. This modifier should be reported to identify surgical assistant services performed in a non-teaching setting when a resident was available, but the surgeon opted not to use the resident. In the latter case, the service is generally not covered by Medicare. When the surgical services are performed in anon-teaching setting, report "Non-teaching" in the narrative section of an electronic claim submission, or in item 24D for paper claims.
82	**Assistant Surgeon (when qualified resident surgeon not available):** The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).

Source:

Novitas Solutions Modifiers at: https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00003604

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One St. Jude Medical Dr., St. Paul, MN 55117, USA, Tel: 1 651 756 20003200
Lakeside Dr., Santa Clara, CA 95054 USA Tel: 1.800.227.9902