AMA Express Reference

cpt 2015

Level I & HCPCS Level II Modifiers

The following codes, medium descriptors, and abbreviated guidelines are a subset of the AMA's Current Procedural Terminology (CPT) code set. For unabbreviated code descriptors and complete guidelines, please refer to the CPT 2015 codebook or data file.

CPT Level I Modifiers

22 **Increased Procedural Services:** When the work required to provide a service is substantially greater than typically required, it may be reported by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (eg, 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.

23 **Unusual Anesthesia:** Occasionally a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

24 **Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period:** The physician or other qualified health care professional may occasionally indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Day of a Procedure or Other Service:** It may be necessary to indicate that a significant, separately identifiable evaluation and management service was performed by the same physician or other qualified health care professional on the day a procedure or service identified by a CPT code was performed. It may be necessary to indicate that the evaluation and management service was significant beyond the usual preoperative and postoperative work associated with the procedure that was performed. A significant, separately identifiable evaluation and management service may be indicated by some circumstances when the patient's condition requires a significant, separately identifiable service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. **Evaluation and Management Services Outside the Global Period:** For reporting E/M services by the same physician or other qualified health care professional during a postoperative period for a previous procedure or surgery, see modifier 57. For significant, separately identifiable non-E/M services, use modifier 25.

26 **Professional Component:** Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

32 **Mandated Services:** Services related to mandated consultation (eg, second opinion or authorization) may be identified by adding modifier 32 to the basic procedure.

33 **Preventive Services:** When the primary purpose of the service is the delivery of an evaluation and management service that is assigned a CPT Preventive Service Code (eg, 99381-99397 and other preventive service codes identified in preventive service guidelines [eg, Centers for Medicare & Medicaid Services]), the service may be identified by adding modifier 33 to the procedure. For separately reported services specifically identified as preventive, this modifier should not be used.

47 **Anesthesia by Surgeon:** Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not be for local anesthesia.) **Note:** Modifier 47 should not be used as a modifier for the anesthesia procedures.

50 **Bilateral Procedure:** Unless otherwise identified in the listing, bilateral procedures that are performed at the same operative session, should be identified by adding modifier 50 to the appropriate CPT code.

51 **Multiple Procedures:** When multiple procedures, other than E/M services, physical medicine and rehabilitation services or provision of supplies (eg, casts and splints), are performed at the same operative session by the same physician or other qualified health care professional, the primary procedure or service may be identified by adding modifier 51 to the appropriate CPT code. Additional procedures performed during the same session may also be identified by adding modifier 51 to the appropriate CPT code. This does not apply to E/M services or to procedures commonly carried out in conjunction with other procedures performed at the same session. Modifier 51 should not be appended to designated "add-on" codes. Instead of modifier 51, see Appendix D.

52 **Reduced Services:** Under circumstances where a service or procedure is partially reduced or eliminated (under the advice of the physician or other qualified health care professional). **Note:** For unplanned return to the operating room for a related procedure during the postoperative period, see modifier 78. For unplanned return to the operating room for a separate procedure during the postoperative period, see modifier 79. For unplanned cancellation of a procedure prior to the administration of anesthesia, see modifier 73 and 74 (use modifiers appropriate for ASC hospital outpatient use).

53 **Discontinued Procedure:** Under certain circumstances, the physician or other qualified health care professional may elect to terminate or withdraw a procedure due to extenuating circumstances or those that threaten the well-being of the patient prior to the administration of anesthesia (use modifiers 73 and 74 [use modifiers appropriate for ASC hospital outpatient use]). **Note:** Do not report modifier 53 for elective cancellation or termination of a procedure due to poor patient condition. Use modifier 52 or 74 as appropriate.

54 **Surgical Care Only:** When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 **Postoperative Management Only:** When 1 physician or other qualified health care professional performed the preoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the procedure number.

56 **Preoperative Management Only:** When 1 physician or other qualified health care professional performed the preoperative evaluation and management service and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the procedure number.

57 **Decision for Surgery:** An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 **Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period:** It may be necessary to indicate that the performance of a procedure or service during the postoperative period was planned (staged) or more extensive than the original procedure (unrelated) (staged). (Do not use modifier 58 for the treatment of a postoperative complication [see modifier 78].) For unplanned procedures, use modifier 78. For reporting separately identifiable procedures that are performed during the postoperative period, see modifier 59.

59 **Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other 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. Reasons other than those listed in the definition may be appropriate. It should be used when no more specific modifier is available or when use of a more specific modifier would not clearly describe the circumstances. 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 the same day of a procedure or another E/M service, see modifier 25.

Sample reflects 2014 codes and descriptions

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