Understanding Modifiers
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Introduction

Over the last 20 years, physicians and hospitals have learned that coding and billing are inextricably entwined processes. Coding provides the common language through which the physician and hospital can communicate—or bill—their services to third-party payers, including managed care organizations, the federal Medicare program, and state Medicaid programs.

The use of modifiers is an important part of coding and billing for health care services. Modifier use has increased as various commercial payers, who in the past did not incorporate modifiers into their reimbursement protocol, recognize and accept HCPCS codes appended with these specialized billing flags.

Correct modifier use is also an important part of avoiding fraud and abuse or noncompliance issues, especially in coding and billing processes involving the federal and state governments. One of the top 10 billing errors determined by federal, state, and private payers involves the incorrect use of modifiers.

**What Are HCPCS Modifiers?**

A modifier comprises two alpha, numeric, or alphanumeric characters reported with a HCPCS code, when appropriate.

Modifiers are designed to give Medicare and commercial payers additional information needed to process a claim. This includes HCPCS Level I (Physicians’ Current Procedural Terminology [CPT®]) and HCPCS Level II codes.

The reporting physician appends a modifier to indicate special circumstances that affect the service provided without affecting the service or procedure description itself. When applicable, the appropriate two-character modifier code should be used to identify the modifying circumstance. The modifier should be placed after the usual procedure code number.

The CPT code book, *CPT 2018*, lists the following examples of when a modifier may be appropriate, including, but not limited to:

- Service/procedure is a global service comprising both a professional and technical component and only a single component is being reported
- Service/procedure involves more than a single provider and/or multiple locations
- Service /procedure was either more involved or did not require the degree of work specified in the code descriptor
- Service/procedure entailed completion of only a segment of the total service/procedure
- An extra or additional service was provided
- Service/procedure was performed on a mirror image body part (eyes, extremities, kidneys, lungs) and not unilaterally
- Service/procedure was repeated
Chapter 1: E/M-Related Modifiers 24, 25, 57, and AI

Modifiers 24, 25, 57, and AI may be appended to evaluation and management services only. Each modifier is listed below with its official definition and an example of appropriate use.

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 need to indicate that an evaluation and management service was performed during a postoperative period for reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

Modifier 24 is added to the selected E/M service code to identify the E/M service rendered by the same provider as unconnected and distinct from other services in the patient’s postoperative period.

Example:

A patient who is 45 days status post for a cholecystectomy presents to the same physician for evaluation of pain and bleeding associated with hemorrhoids. The physician performs a level 2 office visit and appends modifier 24 to indicate that today’s visit is unrelated to the patient’s prior cholecystectomy.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician Or Other Qualified Health Care Professional 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 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 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.

Modifier 25 is used to identify an E/M service rendered on the same day as a procedure or service by the same physician or other qualified health care
Chapter 3: Mandated and Preventive Services-Related Modifiers 32 and 33

Modifiers 32 and 33 are used in very specific circumstances dictated by law. For example, modifier 32 indicates that the service being provided has been mandated—that is, formally ordered by a court or other superior official or payer. In the case of modifier 33 (Preventive service), it may be necessary to identify for insurance companies those preventive services that require all health insurance plans to cover preventive services and immunizations without any associated cost sharing for that particular service as the result of health care reform regulations. Each modifier is listed below with its official definition and an example of appropriate use.

32 Mandated Service
Services related to mandated consultation and/or related service (e.g., third party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

Modifier 32 is appended to the appropriate code to designate those services that have been formally ordered by an appropriate agency or organization for a specified purpose.

Example:
The unmarried parents of a 3-month-old female infant are ordered by the court to undergo DNA testing to determine paternity and establish court-ordered visitation and child support as appropriate. The laboratory performing the testing would report the service and append modifier 32 to indicate that the testing is being conducted at the court’s request.

33 Preventive Service
When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force (USPSTF) A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending modifier 33, Preventive Service, to the service. For separately reportable services specifically identified as preventive, the modifier should not be used.

This modifier should be reported with codes that represent preventive services with the exception of those codes that are inherently preventive such as a screening mammography or an immunization recognized by the Advisory Committee on Immunization Practices (ACIP).

Example:
A 67-year-old male patient presents to the office for his annual physical examination and during the course of the encounter, the provider recommends a one-time screening for an abdominal aortic aneurysm (AAA)
Chapter 5: Multiple Surgeon Modifiers: 62 and 66

Modifiers 62 and 66 represent multiple surgeons and may be appended to procedure codes to indicate that the service required the need for more than one surgeon functioning in different capacities. Each modifier is listed below with its official definition and an example of appropriate use.

62 Two Surgeons
When 2 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 cosurgery 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. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

Modifier 62 is appended to the appropriate service code when two surgeons both function as primary surgeons performing independent components of the same procedure.

Example:
A patient undergoes an anterior lumbar spinal fusion of L5 through S1 involving cages and bone grafts. A general surgeon and a spine surgeon work together as cosurgeons; the general surgeon performs the surgical approach, and the orthopaedic surgeon performs the fusion. Each surgeon would report the same CPT® codes and append modifier 62 to each of the service codes assigned to indicate that each physician performed a distinct component of the same operative procedure.
Chapter 8: Laboratory and Pathology-Related Modifiers 90, 91, and 92

Modifiers 90, 91, and 92 are appended to laboratory services under different scenarios and circumstances. Each modifier is listed below with its official definition and an example of appropriate use as applicable.

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.

Modifier 90 should be appended to the procedure code representing the laboratory service that is being submitted to an outside laboratory for processing in lieu of being processed within the practice or clinic of the treating/reporting physician or other qualified health care professional. Typically, the clinician reports the laboratory service but the actual testing occurs at an outside laboratory.

Example:
The clinician orders the patient to have an automated CBC. The phlebotomist performs the blood draw, and the sample is then submitted for processing to the contracted laboratory for the practice. Billing staff append modifier 090 to the code for a CBC to notify the carrier that, while the clinician is submitting the service, testing was done by an outside lab.

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treating the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

Modifier 91 should be appended to the procedure code representing the service to properly identify a subsequent and medically necessary laboratory test being performed on the same day as the same previous laboratory test.
Chapter 9: Miscellaneous
Modifiers: 63, 95, 96, 97, and 99

Modifier 63 indicates the additional work typically involved when a surgical procedure is performed on a small infant; for example, ensuring body temperature control, obtaining IV access, and the operation itself, particularly as it relates to maintaining homeostasis. Generally, this modifier is appended to procedure codes in the range 20005–69990. Because of the complexity of performing procedures on small infants, this modifier was added to capture services performed on neonates and infants within certain weight limitations.

Modifier 95 is appended to procedures from appendix P, a listing of CPT codes commonly reported for services provided in a face-to-face setting that may also be provided as teledicine services using synchronous or “real-time” interactive audio and video communications systems.

Modifiers 96 and 97, new for 2018, are reported by the provider or other qualified health care professional to indicate that a procedure was performed for habilitative or rehabilitative purposes, respectively.

Modifier 99 is reported when more than four modifiers are necessary with a single service. The modifier should be listed next to the CPT® code on the CMS-1500 form with the individual modifiers listed in item 24D of the claim form.

Each modifier is listed below with its official definition and an example of appropriate use.

63 Procedures Performed on Infants Less Than 4 kg
Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20005–69990 code series. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections.

Modifier 63 is appended to the appropriate service code to indicate the additional work and difficulty associated with procedures performed on infants with a body weight of 4 kg or less.

Example:
A physician performs a push transfusion of blood for an infant age 2 weeks, weighing 3.3 kg. Submit CPT code 36440-63 (Push transfusion, blood, 2 years or under). The addition of modifier 63 tells the third-party payer the physician performed the procedure on an infant weighing less than 4 kg.

FOR MORE INFO
Previously, modifier 22 Increased procedural services, was reported to describe those services that were more complex due to the age and size of the patients; however, pediatricians and surgeons now report modifier 63. It is inappropriate to report modifier 22 in conjunction with modifier 63.
Chapter 10: Category II
Modifiers: 1P, 2P, 3P, and 8P

On October 14, 2016, the Department of Health and Human Services (HHS) issued its final rule with comment period implementing the Quality Payment Program that is part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Quality Payment Program policy will reform Medicare payments for over 600,000 clinicians across the country and is a major step in improving care across the entire health care delivery system. Providers are permitted to choose how they wish to participate in the Quality Payment Program based on the size of their practice, specialty, location, or patient population.

The Quality Payment Program is focused on moving the payment system to reward high-value, patient-centered care. To be successful in the long run, the Quality Payment Program must account for diversity in care delivery, giving clinicians options that work for them and their patients.

Providers can choose from two different tracks: advanced alternative payment models (APMs) or the Merit-based Incentive Payment System (MIPS).

An alternative payment model (APM) is a payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

Advanced APMs are a subset of APMs and allow practices to earn more for acquiring some risk related to patients’ outcomes. Providers may earn a 5 percent Medicare incentive payment during 2019 through 2024 and be exempt from MIPS reporting requirements and payment adjustments if they have sufficient participation in an advanced APM. Earning an incentive payment in one year does not guarantee receiving the incentive payment in future years.

MIPS is the acronym for Merit-based Incentive Payment System, under which providers may earn a payment adjustment based on successful reporting of evidence-based and practice-specific quality data. Depending on the clinician’s performance in 2018, the provider could see a positive, neutral, or negative adjustment of up to 4 percent to Medicare payments for covered professional services rendered in 2019. This adjustment percentage grows to a potential of 9 percent in 2022 and beyond. In addition, during the first six payment years of the program (2019–2024), MACRA allows for up to $500 million each year in additional positive adjustments for exceptional performance. In total, MACRA provides for up to $3 billion in additional positive adjustments to successful clinicians over six years.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) replaced three Medicare reporting programs with MIPS (Medicare Meaningful Use, the Physician Quality Reporting System, and the value-based payment modifier). Under the combination of the previous programs, providers faced negative payment adjustments of up to 9 percent total in 2019; MACRA ended those programs,
Chapter 11: HCPCS Level II
Modifiers A–Z

INTRODUCTION
The HCPCS Level II codes are alphanumeric codes developed by the Centers for Medicare and Medicaid Services as a complementary coding system to the AMA's CPT codes. HCPCS Level II codes describe procedures, services, and supplies not found in the CPT book.

Similar to the CPT coding system, HCPCS Level II codes also contain modifiers that further define services and items without changing the basic meaning of the CPT or HCPCS Level II code with which they are reported. However, the HCPCS Level II modifiers differ somewhat from their CPT counterparts in that they are composed of either alpha characters or alphanumeric characters. HCPCS Level II modifiers range from A1 to ZC and include such diverse modifiers as E1 Upper left, eyelid, GJ Opt out physician or practitioner emergency or urgent service, and Q6 Service furnished by a substitute (locum tenens) physician.

It is important to note that HCPCS Level II modifiers may be used in conjunction with CPT codes, such as 69436-LT Tympanostomy (requiring insertion of ventilating tube), general anesthesia, left ear. Likewise, CPT modifiers can be used when reporting HCPCS Level II codes, such as L4396-50. Ankle contracture splint, bilateral (this scenario can also be reported with modifiers RT and LT, depending on the third-party payer's protocol). In some cases, a report may be required to accompany the claim to support the need for a particular modifier's use, especially when the presence of a modifier causes suspension of the claim for manual review and pricing.

AMBULANCE MODIFIERS
For ambulance services modifiers, single alpha characters with distinct definitions are paired to form a two-character modifier. The first character indicates the origination of the patient (e.g., patient's home, physician office, etc.), and the second character indicates the destination of the patient (e.g., hospital, skilled nursing facility, etc.). When ambulance services are reported, the name of the hospital or facility should be included on the claim. If reporting the scene of an accident or acute event (character S) as the origin of the patient, a written description of the actual location of the scene or event must be included with the claim(s).

D Diagnostic or therapeutic site other than “P” or “H” when these are used as origin codes
E Residential, domiciliary, custodial facility (other than 1819 facility)
G Hospital-based ESRD facility
H Hospital
Chapter 12: ASC and Hospital Outpatient Modifiers: 25, 27, 73, and 74

**Ambulatory Payment Classifications**

Since the implementation of Medicare's outpatient prospective payment system (OPPS), effective August 1, 2000, hospital outpatient services including hospital-based ambulatory surgery, and provider-based clinics have been reimbursed under ambulatory payment classifications (APCs). The formulation of the APC grouping system took root in the ambulatory patient groups (APGs) system, devised by the Health Information Systems division of 3M Health Care under a grant from the Centers for Medicare and Medicaid Services (CMS). The APC reimbursement system for surgical procedures and other services, however, is not the same as the APG system (still in use by some payers).

The incorporation of APCs into each facility's internal coding and billing systems as well as clinical operations represents an enormous challenge. It is generally agreed that this system of reimbursement requires greater attention to operational economies and the creation of increased internal efficiencies when compared with the past implementation of the diagnosis-related group (DRG) system of reimbursement for the hospital inpatient arena.

CPT® and certain HCPCS Level II codes map to a particular APC classification that holds a predefined reimbursement amount. The financial welfare of any facility outpatient (OP) department, OP clinic, hospital ASC, freestanding ASC, or private physician practice has always depended on the accurate coding and reporting of services. Now, with reimbursement for some of these health care centers based on the APC system of reimbursement, accurately coding and reporting services have never been more critical. A few simple facts about APCs include the following:

- APCs are groups of services with homogeneous or nearly identical clinical characteristics as well as costs.
- At this time, APCs affect only hospital OP department/clinic and hospital-based ambulatory surgery payment for Medicare patients. (Freestanding ASCs are paid under a different payment system.)
- Physician payments are not affected.
- The APC payment system is correlated to CPT and certain HCPCS Level II codes.
- Many CPT and HCPCS Level II codes map to an APC payment group.
- The encounter date for each patient may include one or more APC services.

The use of modifiers has proven a crucial component to Medicare's appropriate and optimal reimbursement of services under APCs. Modifiers are addressed in

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*Key Point*

Not all third-party payers use the APC system of reimbursement for provider-based ASC and hospital outpatient facility services. There are several major third-party payers currently using—and seemingly satisfied with—the APG system of reimbursement for facility services.
Chapter 13: Modifiers and Compliance

INTRODUCTION
Almost every segment of the health care industry has been affected by the federal government's antifraud and abuse campaigns over the last several years. Investigations of hospital billing practices, especially teaching hospitals, flooded the news media with reports of indictments, sanctions, and out-of-court settlements for millions of dollars. With trepidation seeping into all areas of health care, more of the federal government's charges of fraud and abuse committed by clinical laboratories have been heard nationwide, with tens of millions of dollars being paid back to the government. Home health agencies (HHAs), skilled nursing facilities, and durable medical equipment (DME) companies were then targeted. Finally, physician practices and ambulatory surgery centers (ASCs), in state after state, have been undergoing investigations by the FBI, the Office of Inspector General, and officials from the Centers for Medicare and Medicaid Services (CMS). In June 2000, the OIG released a draft version of a physician compliance guidance document aimed at solo practitioners and small physician groups. The Federal Register of October 5, 2000, disclosed the final version of this compliance guidance. Given that the federal government claims it has recouped inappropriate payments and overpayments and has collected fines totaling, up to this point, several billion dollars, there are no signs that fraud and abuse activities will wane.

This chapter of Optum360 Learning: Understanding Modifiers explains the term “compliance” and provides an overview of the federal government's current efforts to eradicate fraud, waste, and abuse in health care programs. This chapter also provides the reader with logic trees for each modifier. Logic trees should be used by physicians and facilities as self-auditing tools to help ensure correct modifier usage.

WHAT IS COMPLIANCE?
Compliance is a broad term applied to certain aspects of the administrative side of the health care industry. Compliance specifically encompasses the appropriate coding, billing (reporting), and documentation of medical services. In particular, being in compliance suggests the correct reporting of health care services to federal programs such as Medicare or the Children's Health Insurance Program (CHIP). This also applies to other federally funded programs, wholly or in part, such as state Medicaid or medical assistance programs. Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, even private payers have been empowered by this federal legislation to investigate, prosecute, and prevent health care fraud and abuse.

Most third-party payers, managed care organizations, preferred provider organizations, and the like have coding and billing guidelines that must be followed. Noncompliance or false reporting of services (fraud) can lead to

DEFINITIONS

abuse: In medical reimbursement, an incident that is inconsistent with accepted medical, business, or fiscal practices and directly or indirectly results in unnecessary costs to the Medicare program, improper reimbursement, or reimbursement for services that do not meet professionally recognized standards of care or which are medically unnecessary. Examples of abuse include excessive charges, improper billing practices, billing Medicare as primary instead of other third-party payers that are primary, and increasing charges for Medicare beneficiaries but not to other patients.

fraud: Intentional deception or misrepresentation that is known to be false and could result in an unauthorized benefit. Fraud arises from a false statement or misrepresentation that affects payments under the Medicare program. Examples include claiming costs for noncovered items and services disguised as covered items, incorrect reporting of diagnosis and procedures to maximize reimbursement, intentionally double billing for the same services, billing services that were not rendered, etc.
Modifier 22

Does documentation in the medical record/operative report support an increase in the work required to complete the procedure?

Yes

Did the physician write a separate cover letter or report detailing the circumstance?

Yes

Have physician dictate a cover letter or report.

Code the procedure performed and append modifier 22 to CPT code.

Submit the claim with documentation.

Submit the claim with a cover letter and/or report.

No

Do not append the modifier 22 to CPT code.

No

Have physician dictate a cover letter or report.

Submit the claim with CPT code only.

Do not overuse modifier 22. Monitor reimbursements.
Chapter 14: Modifier Official Descriptors

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.

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 need to 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 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 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 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.

26 Professional component: Certain procedures are a combination of a physician or other qualified health care professional component and a
1995 guidelines. Guidelines for determining level and type of evaluation and management services released by the Centers for Medicare and Medicaid Services (CMS) in 1995. These guidelines define levels of history, exam, and medical decision making, and the contributing nature of counseling, coordination of care, nature of presenting problem, as well as time.

1997 guidelines. Guidelines for determining level and type of evaluation and management services released by the Centers for Medicare and Medicaid Services (CMS) in 1997. These guidelines are a more defined measure using bullet points for determining the levels of history, exam, and medical decision making, and the contributing nature of counseling, coordination of care, nature of presenting problem, as well as time.

22. CPT modifier, for use with CPT or HCPCS Level II codes, that identifies when a service provided is greater than that usually required for the listed procedure. Surgical procedures that require additional physician work due to complications or medical emergencies may warrant the use of this modifier. Claims that are submitted with this modifier should have attached supporting documentation that demonstrates the unusual distinction of the service(s).

23. CPT modifier, for use with CPT anesthesia codes, that identifies when a procedure must be done under general anesthesia that would otherwise require no general or local anesthesia.

24. CPT modifier, for use with CPT evaluation and management (E/M) codes, that identifies when an E/M service was performed by the same physician or other qualified health care professional during a postoperative period for a reason(s) unrelated to the original procedure.

25. CPT modifier, for use with CPT evaluation and management (E/M) codes, that identifies when the patient’s condition requires a significant, separately identifiable E/M service above and beyond other service provided or above and beyond the usual preoperative and postoperative care associated with the procedure that was performed on the same date of service. Medical record documentation must clearly support all necessary criteria required for use of the E/M service being reported, including identifying signs or symptoms of the condition for which the service was rendered. Not all payers require a separate diagnosis(ies) when billing for both a procedure and E/M service on the same date of service.

26. CPT modifier, for use with CPT and HCPCS Level II codes, that identifies when a procedure is reported for the professional component only. It is assigned to identify the physician or other qualified health care provider portion of a procedure that is a combination of both the provider component and a technical component. It is used when the provider is interpreting the diagnostic study or laboratory test.

27. CPT modifier, for use with CPT and HCPCS Level II codes, that identifies when a provider has performed multiple separate E/M services in the same outpatient facility on the same patient during the same day.

72-hour rule. Policy requiring billing and payment for certain outpatient services provided on the date of an IPPS admission, or during the three calendar days prior to the date of admission, to be included with the bill and payment for the inpatient admission. Non-IPPS hospitals have a one-day payment window. Also known as the payment window or the three-day rule, this Medicare policy has been adopted by other payers.

95. CPT modifier to be appended to CPT codes identified in Appendix P, which contains a listing of services that are most often performed face-to-face but that may also be provided using real-time (synchronous) interactive audio-visual telecommunications systems. Synchronous telemedicine services describe circumstances where the patient and the clinician interact in real-time despite each party being at a different site. Interaction and communication between parties must be commensurate to the same type and amount of time that would be rendered if the service had been performed face-to-face.

96. CPT modifier for use with codes reported to identify services provided to teach patients new skills needed for functions of daily living. The types of services performed are considered habilitative in nature.

97. CPT modifier for use with codes reported to identify services provided to reteach a patient skills needed for functions of daily living that have been lost or impaired due to disease or injury. The types of services performed are considered rehabilitative in nature.

AAPC. American Academy of Professional Coders. National organization for coders and billers offering certification examinations based on physician-, facility-, or payer-specific guidelines. Upon successful completion of the selected examination, the credential