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CPT® Modifiers

Specialty Medical Coding Exam Textbook

Step-by-Step • Simple • Precise • Professional • Authentic

Modifiers 22–99 • X{EPSU} Modifiers • 20 Exam-Style Questions • Master Reference Table • Ethics • Specialty Exam Tips • URL References

How to Use This Textbook

Step-by-Step Navigation Guide for Every Modifier

Introduction to CPT® Modifiers

A CPT® modifier is a two-digit numeric or alphanumeric code appended to a procedure or service code to indicate that a service or procedure has been altered by a specific circumstance — but that the definition of the code itself has NOT changed. Modifiers communicate critical information to payers that cannot be expressed by the procedure code alone.

> *"Neglecting to use modifiers can lead to claim rejections, decreased revenue, or required reimbursements. Modifiers play a crucial role in ensuring both regulatory compliance and accurate reimbursement. It is essential for providers to master the correct documentation of modifiers within patient medical records."*
>
> **— AMA CPT® Appendix A Guidelines**

KEY RULES

- All CPT® modifiers are listed and defined in Appendix A of the CPT® manual. Tab and highlight this appendix in your exam manual.
- Modifiers do NOT change the definition of a procedure code. They only provide additional information.
- Modifiers must always be supported by documentation in the medical record.
- Some modifiers apply only to E/M codes (24, 25, 57). NEVER apply these to surgical procedure codes.
- Some modifiers apply only to surgical/procedure codes (54, 55, 56, 58, 62, 66, 78, 79). NEVER apply these to E/M codes.
- Add-on codes (Appendix D) and modifier 51-exempt codes (Appendix E) should NOT receive modifier 51.
- For specialty exams modifier questions frequently test the distinction between similar modifiers: 22 vs. 63, 24 vs. 25 vs. 57, 52 vs. 53, 54/55/56, 58 vs. 78 vs. 79, 62 vs. 66, 76 vs. 77.

How to Approach Any Modifier Question: 5-Step Method

Step 1: **Read the clinical scenario carefully.** Identify: Who is the provider? What procedure was performed? Was it the same day, during global period, or a new encounter?

Step 2: **Identify the service type:** Is it an E/M code, a procedure code, or a lab code? This determines which modifier can be used.

Step 3: **Identify the timing:** Same day as the procedure? Day before major surgery? During the global period? After the global period? Each timing maps to a specific modifier.

Step 4: **Ask the key clinical question:** Is the second service related or unrelated? Planned or unplanned? Same surgeon or different surgeon? Bilateral or unilateral?

Step 5: **Confirm with Appendix A:** Always verify modifier definition and any restrictions. Check Appendix D (add-on codes) and Appendix E (modifier 51 exempt) before using modifier 51.

ETHICS IN MEDICAL CODING

- Medical coders have an ethical responsibility to use modifiers that truthfully reflect the clinical circumstances documented in the medical record.
- Modifier abuse — appending a modifier solely to obtain payment without clinical justification — constitutes fraud under the False Claims Act (31 U.S.C. § 3729).
- Modifier 25 is one of the most audited modifiers by the OIG (Office of Inspector General). Always verify that the E/M documentation stands completely independent of the procedure note.
- Modifier 59 is the most commonly abused modifier. CMS introduced the X{EPSU} modifiers (XE, XP, XS, XU) in 2015 specifically to reduce this abuse through greater specificity.
- Never add a modifier to bypass a NCCI edit without verifying the medical record supports that use. Doing so without documentation is a billing compliance violation.

SPECIALTY EXAM TIPS

- The exam is open book. Tab Appendix A (Modifiers) in your CPT® manual before the exam.
- Modifier questions appear throughout all specialty sections of the exam. Know modifiers across all settings — office, hospital, ASC, and lab.

- The most frequently tested modifiers on specialty exams: 22, 24, 25, 26, 50, 51, 57, 58, 59, 62, 78, 79.
- For any question involving two physicians or two surgeons, immediately consider: 54/55/56 (split care), 62 (co-surgeons), 66 (surgical team), 80/81/82 (assistants).
- For any question involving the global period, map the scenario to: 24 (unrelated E/M), 57 (decision for surgery), 58 (staged/related), 78 (unplanned OR return), 79 (unrelated procedure).

CHAPTER 1

Modifiers 22 • 23 • 32 • 33 • 47 • 63 • 66 • 99 — Service Circumstance Modifiers

Modifier 22 — Increased Procedural Services

Increased procedural service(s) when the work required to provide a service is substantially greater than typically required. Its primary purpose is to denote circumstances for which a procedure or service required an unusual amount of time or effort to perform. This modifier indicates that a procedure was complicated, complex, difficult, or took significantly more time than usually required. Documentation must support the substantial additional work and the reason for the additional work. Send a special report to the insurance carrier that describes the unusual nature of the service and justifies the additional charge.

☑ WHEN TO USE

- Procedures or surgeries performed that are significantly greater than usually required.
- Anatomical variants that greatly complicate the procedure.
- Trauma that significantly complicates a procedure and cannot be reported with any other code.
- Significant scarring or adhesions that require extra time and work.
- Morbid obesity requiring extra physician work.
- Excessive blood loss significantly beyond what is typical for the procedure.
- Pathologies, tumors, or malformations (genetic, traumatic, surgical) that directly interfere with the procedure.
- Conversion of a procedure from laparoscopic to open with significant scarring or adhesions.

✗ DO NOT USE / COMMON PITFALLS

- Do NOT assign modifier 22 if there is no supportive documentation.
- Do NOT use modifier 22 when an existing code already describes the service more precisely.
- Do NOT append modifier 22 to secondary procedure codes.
- Do NOT use modifier 22 for re-operations (use modifier 78 or 79 as appropriate).

- Do NOT use modifier 22 for Evaluation and Management (E/M) services.
- Do NOT substitute an unlisted procedure code to avoid carrier denials instead of using modifier 22.
- For procedures on neonates/infants less than 4 kg, use modifier 63 instead of modifier 22.

DOCUMENTATION REQUIRED FOR MODIFIER 22

- Time: Document additional time spent performing the procedure compared to typical.
- Blood loss: Document quantity of blood lost and compare with usual blood loss.
- Special equipment used during the procedure.
- Technique changes, conversion, or alterations in the standard approach.
- Submit a special report (operative note + cover letter) with the claim.

CODING TIP

- Modifier 22 can be used in: Anesthesia, Surgery, Radiology, Pathology and Laboratory, and Medicine sections.
- Even when justified, obtaining higher-than-normal reimbursement can be difficult. Many payers review modifier 22 claims manually.
- The special report must clearly explain WHY the work was substantially greater — not just that it was.

Example 1:

During a colonoscopy, the gastroenterologist removes 20 polyps using hot biopsy forceps and spends 2 hours for the procedure.

45384-22 Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps

Even though the CPT® code describes polyps (plural), the physician work exceeded the usual procedure. Append modifier 22.

Example 2:

The surgeon performs a laparoscopic cholecystectomy with exploration of the common bile duct. During the procedure, multiple adhesions are

encountered. The surgeon spends two additional hours removing adhesions.

47564-22 Laparoscopy, surgical; cholecystectomy with exploration of common duct

Modifier 22 is reported because additional surgeon effort beyond the typical procedure was required.

Modifier 23 Unusual Anesthesia

Under some circumstances, general anesthesia is given when normally either local anesthesia or no anesthesia is provided. CPT® Appendix A states: "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."

☑ WHEN TO USE

- Use when a procedure that normally uses local or no anesthesia requires general anesthesia due to unusual circumstances.
- Document medical necessity clearly — explain WHY general anesthesia was necessary.

✕ DO NOT USE / COMMON PITFALLS

- Do NOT use modifier 23 for procedures that include the term 'without anesthesia' in their description.
- Do NOT use modifier 23 for procedures normally performed under general anesthesia.
- Do NOT use for moderate (conscious) sedation.
- Do NOT report with anesthesia section procedure codes (00100–01999).

Example:

A cystoscopy (normally performed under local or no anesthesia in adults) is performed on a 3-year-old child who cannot cooperate. General anesthesia is required.

52000-23 Cystourethroscopy (with or without calibration/urethral dilation) + Unusual Anesthesia

The physician documented in the record that the patient could not cooperate for the procedure under local anesthesia, thus necessitating general anesthesia.

Modifier 32 Mandated Services

Modifier 32 is appended to any service that the physician provides at the specific request of the patient's insurer or other third-party payer. Append modifier 32 for mandated consultation and/or other services. These services are flagged because they are required by a third party, e.g., a court of law, agency, or insurance entity. The use of this modifier does NOT affect payment.

KEY RULES

- Mandated services are those requested by an insurance carrier, peer review organization, utilization review panel, HMO, PPO, court of law, or other entity.
- Typically the request is for a second or third opinion regarding a patient's illness or treatment.
- Modifier 32 alerts claim processors that the claim needs special handling.

Example:

A 36-year-old male prisoner is referred to a gastroenterologist by the state for evaluation of jaundice. The physician performs a detailed examination and diagnoses viral hepatitis A. Level 4 service is provided.

99244-32 Office consultation, level 4 — Mandated Service

Modifier 33 Preventive Services

When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating, or other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding modifier 33. This modifier

was introduced in connection with reforms under the Patient Protection and Affordable Care Act (PPACA), requiring all health care insurance plans to cover preventive services without cost-sharing.

FOUR CATEGORIES WHERE MODIFIER 33 APPLIES

- Services rated 'A' or 'B' by the US Preventive Services Task Force (USPSTF) — www.uspreventiveservicestaskforce.org
- Immunizations for routine use in children, adolescents, and adults (ACIP recommendations, CDC).
- Preventive care and screenings for children as recommended by Bright Futures (American Academy of Pediatrics) and Newborn Testing (American College of Medical Genetics) via HRSA.
- Preventive care and screenings provided for women (not included in the Task Force recommendations) per HRSA comprehensive guidelines.

Example:

Abdominal aortic aneurysm (AAA) screening is recommended by USPSTF for certain populations. CPT® code 76705 (ultrasound, abdominal, real time with image documentation, limited) is used for AAA screening.

`76705-33 Ultrasound, abdominal, limited — Preventive Service (no cost-sharing)`

Modifier 33 indicates to the payer that this is a covered preventive service and patient cost-sharing (copay, coinsurance, deductible) must be waived.

Modifier 47 — Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic surgical service. This modifier alerts the third-party payer that the surgeon personally performed the anesthesia.

✕ DO NOT USE / COMMON PITFALLS

- Do NOT report modifier 47 for topical anesthesia, local infiltration, or metacarpal/metatarsal/digital blocks.
- Do NOT use modifier 47 as a modifier for the Anesthesia section procedure codes (00100–01999).

- Do NOT append modifier 47 for Moderate (Conscious) Sedation.

Example:

The operating surgeon performed a regional nerve block (code 64415) prior to performing carpal tunnel decompression (code 64721). The surgeon personally administered the regional anesthesia.

64721-47 Neuroplasty and/or transposition; median nerve at carpal tunnel + Anesthesia by Surgeon

Modifier 47 is appended to the surgical code 64721 to indicate the surgeon provided the anesthesia. Code 64415 is also reported for the specific nerve block.

Modifier 63 — Procedure 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 work. This circumstance may be reported by adding modifier 63 to the procedure number. This modifier may ONLY be appended to procedures/services listed in the 20005–69990 code series (Surgery section).

✕ DO NOT USE / COMMON PITFALLS

- Do NOT append modifier 63 to codes in: Evaluation and Management, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections.
- Do NOT use modifier 63 together with modifier 22 for these cases — modifier 63 replaces modifier 22 for neonates/infants under 4 kg.
- Check Appendix F for codes exempt from modifier 63. These are also identified in the CPT® codebook with a parenthetical '(Do not report modifier 63 in conjunction with XXXXX)'.

Example:

A pediatric surgeon performs an emergency colostomy on a newborn baby of 3.5 kg with imperforate anus. The baby has not passed meconium 3 days after birth.

44320-63 Colostomy or skin-level cecostomy + Procedure on Infant <4 kg

Modifier 63 reflects the increased complexity and physician work associated with performing surgery on a neonate under 4 kg.

Modifier 66 — Surgical Team

Under some circumstances, highly complex procedures requiring the concomitant services of several physicians or other qualified health care professionals — often of different specialties, plus highly skilled personnel and complex equipment — are carried out under the "surgical team" concept. Each participating individual reports the same CPT® code with modifier 66 appended.

KEY RULES

- Surgical Team (modifier 66) applies when THREE OR MORE primary surgeons work together to complete a single CPT® procedure.
- Important: Two surgeons + one or more surgical assistants does NOT qualify as a surgical team. Modifier 66 requires three or more PRIMARY surgeons.
- If three or more surgeons each perform a distinct, separately identifiable procedure at the same session (each has its own CPT code), this is sequential surgery — each surgeon bills independently with no modifier.
- CMS reviews modifier 66 claims case-by-case. Team surgery is paid on a 'By Report' basis.
- Each physician must document separately and submit their own claim.

CMS PHYSICIAN FEE SCHEDULE — TEAM SURGERY INDICATORS

- TEAM SURG = 1: Medicare may allow modifier 66 with supporting documentation of medical necessity.
- TEAM SURG = 2: Medicare will permit modifier 66 with this code (e.g., major organ transplants: lung 32851-32854, heart 33945).
- TEAM SURG = 0 or 9: Never apply modifier 66 to this code.
- Check the MPFS database at: www.cms.gov/apps/physician-fee-schedule/

Modifier 99 — Multiple Modifiers

Under certain circumstances, two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

CODING TIP

- Modifier 99 is used primarily for paper claims where space limits the number of modifiers that can be entered.
- On electronic claims (ANSI X12 837P), most systems can accommodate multiple modifiers directly without needing modifier 99.

CHAPTER 2

Modifiers 24 • 25 • 57 — Evaluation & Management Modifiers

> *"The most important rule about E/M modifiers: Modifiers 24, 25, and 57 apply ONLY to Evaluation and Management (E/M) codes. NEVER append these modifiers to a surgical or procedure code."*
>
> **— AMA CPT® Appendix A — E/M Modifier Guidelines**

Modifier 24 — Unrelated E/M Service by the Same Physician 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 unrelated to the original procedure. Payment for the E/M service during the postoperative period is made when the reason for the E/M service is unrelated to the original procedure.

KEY RULES

- NEVER USE MODIFIER 24 ON A CPT® SURGICAL CODE. It applies to E/M codes only.
- Any E/M service during the global period that IS related to the surgery is part of the global surgical package and is NOT separately payable.
- This modifier is only for E/M service during the postoperative period that begins the DAY AFTER the procedure. Do not use for same-day services.
- The visit diagnosis (ICD-10-CM) must differ from the surgical diagnosis to demonstrate it is unrelated.
- Same physician (or same specialty/same group) who performed the original procedure provides the unrelated E/M.
- Supporting documentation and the ICD-10-CM code reflecting the reason for the E/M must be submitted with the claim.
- Assign modifier 79 (not 24) for an unrelated PROCEDURE during the global period.
- Assign modifier 78 if the surgeon must treat complications in the OR during the global period.

Example 1:

Patient had laryngectomy 3 weeks ago. Today the patient presents for acute otitis media.

E/M code-24 (e.g., 99213-24)

The visit is in the postoperative period and is unrelated to the original laryngectomy. Report the appropriate E/M code with modifier 24.

Example 2:

Patient presents within 2 weeks of postoperative period of parotid tumor excision, now with acute maxillary sinusitis.

E/M code-24 (e.g., 99213-24)

Example 3 (Exam-Style):

4 weeks after a femur fracture repair, an E/M service is performed for thoracic neuritis (M54.4). Expanded problem focused history, exam, and low complexity MDM.

99213-24 Office visit, established patient, level 3 + Unrelated E/M During Post-op Period

ICD-10-CM: M54.4 Lumbago with sciatica (unrelated to femur fracture)

Modifier 25 — Significant, Separately Identifiable E/M Service on the Same Day of the Procedure

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. The E/M service may be prompted by the symptom or condition for which the procedure was provided. Different diagnoses are NOT required.

KEY RULES

- NEVER USE MODIFIER 25 ON A CPT® SURGICAL CODE. It applies to E/M codes only.
- The procedure and medically necessary E/M must occur on the SAME DAY by the SAME provider.
- Modifier 25 applies when the same-day procedure is a MINOR procedure (0-day or 10-day global period).

- For E/M on the same day as a MAJOR procedure (90-day global), use modifier 57 (Decision for Surgery) instead.
- The E/M must be 'above and beyond' the minimal evaluation normally associated with the procedure.
- The physician must document a separate and complete H&P and medical decision making for the E/M, separate from the procedure note.
- Different diagnoses are not required but ARE reported when appropriate.

✗ DO NOT USE / COMMON PITFALLS

- Do NOT use modifier 25 when the E/M service is not above and beyond the primary purpose of the patient encounter.
- Do NOT use modifier 25 if the sole reason for the visit was the procedure itself.
- Do NOT use modifier 25 when only lab or X-ray services are provided in addition to the E/M.
- Do NOT use modifier 25 with major surgical procedures (90-day global period) — use modifier 57.
- Do NOT use modifier 25 instead of modifier 57 for E/M that resulted in the decision to perform major surgery.
- Documentation must fully substantiate that the E/M is both significant and separately identifiable.

Example 1 (Appropriate use):

Patient sees physician for knee pain. The physician examines the patient, meets all E/M criteria, and determines the patient needs a joint injection. Physician provides both the E/M and the injection.

```
99213-25  Office visit (knee pain evaluation) + Modifier 25
20610     Aspiration and/or injection, major joint
```

Example 2 (NOT appropriate use):

The same patient returns 2 weeks later for a planned injection for the same complaint. The physician may NOT bill an office visit with modifier 25 — only the injection is billable since the encounter was pre-planned for the procedure.

Example 3 (Appropriate use):

Patient presents for hypertension. After examination, the patient asks about skin tags. Physician performs a full examination, makes a separate medical decision to remove 13 skin tags, and removes them.

```
99213-25  Office visit (hypertension) + Modifier 25
11200     Removal of skin tags, up to 15 lesions
```

Example 4 (NOT appropriate — acne):

Jessica, age 17, presents to dermatologist for acne. The patient is seen, medication is ordered, and acne cysts are injected. In this case, the E/M service is INCLUDED in the acne surgery — modifier 25 is not appropriate.

Modifier 57 — Decision for Surgery

Modifier 57 identifies an Evaluation and Management service that results in the initial decision to perform surgery. Append modifier 57 to the E/M service code, NOT the surgical or medical procedure code. Failure to append modifier 57 to the E/M code will result in the payer bundling the E/M service into the global surgical package, resulting in a loss of reimbursement.

KEY RULES

- Modifier 57 applies to E/M services that occur on the DAY OF or the DAY BEFORE a MAJOR surgical procedure (90-day global period).
- The E/M service must DIRECTLY LEAD to the surgeon's decision to perform surgery.
- The surgical procedure following the E/M must have a 90-DAY global period.
- The same physician/QHP provides both the E/M service and performs the surgical procedure.
- APPEND MODIFIER 57 TO THE E/M CODE — NEVER TO THE SURGICAL CODE.
- For E/M on the same day as a MINOR procedure (0 or 10-day global), use modifier 25 instead.
- If the physician has already scheduled surgery and provides a final routine E/M prior to surgery, that E/M is NOT separately reported.

Example 1:

Patient presents to ED with acute lower abdominal pain. General surgeon evaluates the patient, diagnoses ruptured appendix with peritonitis, and immediately performs an appendectomy.

```
99285-57  ED E/M, high complexity + Decision for Surgery
44960     Appendectomy for ruptured appendix with generalized peritonitis
```

Example 2:

Surgeon evaluates patient for acute right upper quadrant pain. Following a full evaluation, the surgeon decides to perform a laparoscopic cholecystectomy immediately.

```
99244-57  Office consultation, level 4 + Decision for Surgery
47562     Laparoscopy, surgical; cholecystectomy
```

Example 3 (NOT separately reportable):

The surgeon schedules a cholecystectomy for a patient with a diseased gallbladder. On the day prior to surgery, the surgeon meets with the patient only to discuss the upcoming procedure and answer questions.

This E/M is NOT separately reportable — it is included in the global surgical package as the pre-operative visit.

Modifier 24 vs. 25 vs. 57 — Side-by-Side Comparison

Feature	Modifier 24	Modifier 25	Modifier 57
Applied to	E/M code ONLY	E/M code ONLY	E/M code ONLY
Timing	During post-op period (NOT same day)	Same day as procedure	Same day or day before major surgery
Relationship to surgery	Unrelated to original surgery	May be related (same complaint) or unrelated	E/M directly leads to decision for surgery
Global period of surgery	0, 10, or 90-day post-op period active	Minor procedure (0 or 10-day global)	Major procedure (90-day global) only
Different diagnosis required?	YES — must be unrelated to surgery	NO — but document when applicable	NO — but must document decision for surgery
Same or different surgeon?	Same surgeon/group who did original surgery	Same surgeon/provider same day	Same surgeon who will perform the surgery

CHAPTER 3

Modifiers 26 • 50 • 51 • 52 • 53 • 76 • 77 • 90 • 91 • 92 — Procedural & Service Modifiers

Modifier 26 — Professional Component

Certain procedures are a combination of a physician (professional) component and a technical component. When the professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number. These two-component services are usually associated with radiology, pathology, and medicine services.

Component	What It Includes	Modifier	RVU Split (Approximate)
Professional Component (PC)	Physician/QHP interpretation, medical decision making, and written report	Modifier 26	~60% of total RVU
Technical Component (TC)	Facility, equipment, film/digital processing, supplies, and technician	Modifier TC (HCPCS)	~40% of total RVU
Global (both components)	Physician owns equipment AND interprets; provides both components	No modifier	100% of total RVU

KEY RULES

- Apply modifier 26 ONLY to codes that have both a professional and a technical component.
- If the physician provides BOTH components (e.g., performs the procedure in their own office using their own equipment), report the CPT® code with NO modifier.
- Procedures/services with two components are commonly found in the Radiology, Pathology and Laboratory, and Medicine sections.

Example (Radiologist interpretation only):

Patient is referred to a hospital for a chest X-ray. The hospital takes the X-ray (technical component) and sends it to a radiologist who interprets it (professional component).

71045-26 Radiologic examination, chest; single view + Professional Component

The hospital bills 71045-TC for the technical component. The radiologist bills 71045-26 for the professional component.

Example (Physician provides both):

A physician performs a pelvic ultrasound in their own office using their own equipment and interprets the results.

76856 Complete pelvic ultrasound (NO modifier — both components provided)

Modifier 50 — Bilateral Procedure

Unless otherwise identified in the listing, bilateral procedures performed at the same session should be identified by adding modifier 50 to the appropriate five-digit code. A bilateral procedure is the same procedure performed on both sides of the body.

THREE WAYS TO REPORT BILATERAL PROCEDURES (carrier-specific)

- Format 1 (Medicare): Single line item with modifier 50 appended — e.g., 73110-50, quantity 1.
- Format 2: Two line items with modifier 50 on second line — e.g., 73110 (line 1), 73110-50 (line 2).
- Format 3: HCPCS modifiers LT/RT in place of modifier 50 — e.g., 73110-RT and 73110-LT.
- For medical coding/billing exams, the answer option will be specific. Choose the format presented.

✕ DO NOT USE / COMMON PITFALLS

- Do NOT assign modifier 50 to procedures that are inherently bilateral by definition (e.g., 42507 Parotid duct diversion, bilateral). The code descriptor already states 'bilateral.'
- Always check CPT® notes above and below the code — the manual will indicate whether bilateral usage is already included.

Example (Inherently bilateral — NO modifier 50):

The physician performed parotid duct diversion.

42507 Parotid duct diversion, bilateral (Wilke type procedure) — Do NOT add modifier 50

Example (Bilateral applied):

The surgeon performs repair of initial inguinal hernia on both the left and right sides of a 5-month-old infant.

49495 Repair initial inguinal hernia, preterm infant (younger than 37 weeks), younger than 6 months

49495-50 Same procedure, bilateral

Modifier 51 — Multiple Procedures

When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provisions 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.

KEY RULES

- The primary procedure or service (highest Relative Value Unit) is listed FIRST — no modifier.
- Modifier 51 is appended to all additional (secondary, tertiary) procedures.
- Do NOT append modifier 51 to designated Add-on codes (Appendix D) or modifier 51-exempt codes (Appendix E).
- CMS pays 100% for the first procedure and 50% for the second through fifth procedures.
- Do NOT reduce the charge amount on the claim — bill full charges and allow the payer to apply the reduction.
- RVUs are not in the CPT® manual. For exam purposes, the highest-valued procedure is listed first.

Modifier 51 Reimbursement Model

Procedure	Code	RVU / Value	Payment Rule	Payment Amount
Primary (highest value)	Code X	$100	100% of allowable	$100
Second procedure	Code Y - 51	$80	50% of allowable	$40
Third procedure	Code Z - 51	$60	50% of allowable	$30
Total reimbursement		$240		$170

Example 1:

Patient presents for removal of a 1.0 cm malignant lesion on the nose with a 3.0 cm complex repair of the defect.

11641 Excision, malignant lesion, face, 1.0 cm (primary — highest RVU)

13152-51 Complex repair, trunk, scalp, axillae, genitalia or extremities; 2.6 cm to 7.5 cm (modifier 51)

Example 2:

Physician performed EGD with dilation of gastric outlet (43245) and single biopsy (43239).

43245 EGD with dilation of gastric outlet (primary)

43239-51 EGD, with biopsy, single or multiple (modifier 51)

Modifier 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 can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced.

KEY RULES

- Modifier 52 is appended to the procedure code (not E/M codes).
- Submit the detailed operative report and a concise statement about how the service or procedure differs from what would be considered ‘usual’ or ‘normal.’
- When a procedure normally performed bilaterally is only performed on one side, report with modifier 52.

- Individual payer/carrier policies for modifier 52 vary — verify with the payer.

✕ DO NOT USE / COMMON PITFALLS

- Do NOT use modifier 52 when a more specific existing code describes the reduced service. Example: If a 2-view chest X-ray is ordered but only 1 view is performed, report 71045 (single view) — NOT 71046-52 (2-view with modifier 52).

Example:

A 14-year-old female underwent tonsillectomy and adenoidectomy 6 years ago. A secondary (regrown) tonsil has appeared on the LEFT side only. The surgeon performs tonsillectomy on the left side only.

```
42826-52  Tonsillectomy, primary or secondary; age 12 or over
+ Reduced Services (one side only)
```

Modifier 53 — Discontinued Procedure

CPT® Appendix A states: "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."

KEY RULES

- Modifier 53 describes an unexpected problem, beyond the physician's or patient's control, that necessitates terminating the procedure.
- Document the circumstances clearly. The diagnosis code should reflect WHY the procedure was terminated.
- Modifier 53 is NOT used to report the elective cancellation of a procedure prior to anesthesia induction and/or surgical preparation.
- For ASC facility reporting of discontinued procedures, use modifier 73 (before anesthesia) or modifier 74 (after anesthesia) instead.

Modifier 52 vs. 53 Decision Matrix

Decision Matrix	Modifier 52	Modifier 53
Anesthesia (if applicable)	Procedure stopped PRIOR to anesthesia	Procedure stopped AFTER anesthesia administered
Who decides to stop	Elective by patient or physician	Physician terminates due to patient risk/safety
Applies to ASC?	No (use modifier 73 for ASC)	No (use modifier 74 for ASC)
New global period?	No	No

Example:

A patient develops a cardiac arrhythmia during a diagnostic indirect laryngoscopy with biopsy (31510). The procedure is discontinued by the physician because the patient's condition poses a significant risk.

31510-53 Laryngoscopy, indirect; with biopsy + Discontinued Procedure

Modifier 76 — Repeat Procedure or Service by Same Physician

Modifier 76 is appended to indicate that a procedure or service was repeated subsequent to the original procedure or service by the same physician or other qualified health care professional. This prevents the second claim from being rejected as a duplicate.

Example:

A patient has a chest X-ray (2 views) in the morning for worsening cough. The same physician repeats the same X-ray in the evening after the patient returns with worsening symptoms.

71046 Radiologic examination, chest; 2 views (first X-ray)

71046-76 Radiologic examination, chest; 2 views + Repeat by Same Physician (second X-ray)

Modifier 77 — Repeat Procedure by Another Physician or Other Qualified Health Care Professional

Modifier 77 is used when the exact same procedure is repeated by a different physician or other qualified health care professional. The modifier signals to the payer that the repeated claim is not a duplicate.

CODING TIP

- The key distinction: modifier 76 = same physician repeats the procedure. Modifier 77 = different physician repeats the same procedure on the same day.

Modifier 90 — Reference (Outside) Laboratory

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

CODING TIP

- Modifier 90 is used when a physician orders a lab test, but sends the specimen to an outside (reference) laboratory for testing rather than performing it in-house.

Modifier 91 — Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of 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.

✕ DO NOT USE / COMMON PITFALLS

- Do NOT use modifier 91 when tests are rerun to confirm initial results due to testing problems with specimens or equipment.

- Do NOT use modifier 91 when a normal, one-time, reportable result is all that is required.
- Do NOT use modifier 91 with codes that describe a series of test results (e.g., glucose tolerance test, evocative/suppression testing).
- Modifier 91 may ONLY be used for laboratory tests performed MORE THAN ONCE on the same day on the same patient.

Modifier 92 — Alternative Laboratory Platform Testing

When laboratory testing is performed using a kit or transportable instrument that wholly or in part consists of a single-use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (for example, HIV testing 86701–86703 and 87389–87391). The test does not require permanent dedicated space and may be hand carried or transported to the vicinity of the patient for immediate testing at that site.

CHAPTER 4

Modifiers 54 • 55 • 56 • 58 • 62 • 73 • 74 • 78 • 79 • 80 • 81 • 82 — Surgical & Global Period Modifiers

> *"Every procedure with a global surgical package consists of three parts: preoperative services, the surgical service (intraoperative), and postoperative care. When care is split between physicians, these modifiers ensure each provider is correctly reimbursed for their portion of the global package."*
>
> **— AMA CPT® Surgical Package Guidelines — Modifiers 54/55/56**

Split Surgical Care — Modifiers 54, 55, 56

Every procedure with a global surgical package consists of three parts: (1) preoperative services, (2) the surgical service (intraoperative portion), and (3) postoperative care. When physicians agree on the transfer of care during the global period, these modifiers are used:

Modifier	Name	Who Uses It	CMS Payment Percentage
54	Surgical Care Only	Surgeon who performs the operation but not pre/post care	~70% of global payment (intraoperative component)
55	Postoperative Management Only	Physician who provides post-op follow-up only	~20% of global payment (postoperative component)
56	Preoperative Management Only	Physician who provides pre-op evaluation only	~10% of global payment (preoperative component)

Modifier 54 — Surgical Care Only

When one physician 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. Split care is

most common when patients are on vacation or out of town and require follow-up with their home physician after a major procedure.

Example:

Dr. A performs fistulectomy (46275) at an ASC. Dr. A visits the ASC only once per week. Pre- and postoperative care is provided by another physician at the ASC.

46275-54 Fistulectomy, intersphincteric + Surgical Care Only

Modifier 55 — Postoperative Management Only

The physician or other qualified health care professional who provides only the postoperative care is paid the postoperative percentage of the global service, because another physician performed the surgical procedure. Modifier 55 is attached to the surgical procedure code, NOT to an E/M service code.

Example:

Dr. A performed laparoscopic appendectomy (44970) and immediately traveled out of town for a medical conference. Dr. B agreed to provide postoperative care for the patient.

44970-55 Laparoscopic appendectomy + Postoperative Management Only (Dr. B)

44970-54 Laparoscopic appendectomy + Surgical Care Only (Dr. A)

Modifier 56 — Preoperative Management Only

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

Example:

Patient is scheduled for external hemorrhoidectomy (46250). Dr. A is busy with an emergency the day before surgery and arranges for Dr. B

to provide preoperative management. Dr. A performs the surgery as scheduled.

46250-56 External hemorrhoidectomy + Preoperative Management Only (Dr. B)

46250-54 External hemorrhoidectomy + Surgical Care Only (Dr. A)

Modifier 58 — Staged or Related Procedure During the Postoperative Period

The physician/other qualified clinician may need to indicate that the performance of a procedure or service during the postoperative period was: (1) planned or anticipated (staged) at the time of the original procedure; (2) more extensive than the original procedure; or (3) for therapy following a diagnostic surgical procedure.

KEY RULES

- Modifier 58 is used when the second procedure is RELATED to or PLANNED from the original procedure.
- The staged procedure billed with modifier 58 WILL begin a NEW global period.
- Applied to the PROCEDURE CODE, not an E/M code.
- For complications requiring a return to the OR, use modifier 78 instead.
- For truly unrelated procedures during the global period, use modifier 79.

✕ DO NOT USE / COMMON PITFALLS

- Do NOT use modifier 58 when a total knee arthroplasty (27447) is followed by manipulation under anesthesia for adhesions (27570) — the arthroplasty is therapeutic, not diagnostic; use modifier 78 for complications or no modifier if beyond global period.
- Do NOT use modifier 58 for a truly unrelated procedure during the global period — use modifier 79.

Example 1:

Patient has a breast lesion removed (19120). Within 90 days, adenocarcinoma is confirmed and the entire breast is removed (19303).

19303-58 Mastectomy, simple, complete + Staged/Related Procedure

Example 2:

Patient with gangrene has a toe amputated. On follow-up, the entire foot must be removed as the original procedure did not resolve the problem.

[Second amputation code]-58 + Staged/Related Procedure

Modifiers 58 vs. 78 vs. 79 — Critical Comparison

Modifier	Name	Relationship to Original Surgery	New Global Period?	Applies to
58	Staged/Related Procedure	Related or planned at time of original surgery	YES — new global period begins	Same surgeon, during post-op
78	Unplanned Return to OR	Related — complication of original surgery	NO — continues original global period	Same surgeon, return to OR
79	Unrelated Procedure	Unrelated to original surgery	YES — new global period begins	Same surgeon, during post-op

Modifier 59 — Distinct Procedural Service

The purpose of modifier 59 is to prevent a service from being bundled into the payment of another procedure performed on the same day. Payers may base bundling decisions on CPT® guidelines, Medicare's NCCI (CCI), or internal policies. Modifier 59 is used to indicate situations in which codes not normally reported together are being submitted because of special clinical circumstances.

KEY RULES

- Modifier 59 can be used to indicate: different encounters, different anatomic sites, or distinct services.
- Modifier 59 should NOT be attached to an E/M service.

- Modifier 59 is the MOST USED and MOST ABUSED modifier. CMS created the X{EPSU} modifiers in 2015 as more specific subsets.
- Use X{EPSU} modifiers for Medicare when a more specific modifier applies. Modifier 59 remains valid but CMS encourages adoption of X modifiers.

The X{EPSU} Modifiers — Introduced January 1, 2015

X Modifier	Full Name	When to Use	Clinical Example
XE	Separate Encounter	Service is distinct because it occurred at a separate encounter/time	Diagnostic nasal endoscopy at 10 AM; control of epistaxis at 8 PM same day (separate ER visit)
XP	Separate Practitioner	Service is distinct because performed by a different practitioner	Physician A performs wound culture; Physician B performs second culture from a different site
XS	Separate Structure	Service is distinct because performed on a separate organ/structure	Arthroscopic synovectomy right knee; diagnostic arthroscopy left knee
XU	Unusual Non-Overlapping Service	Service does not overlap usual components of the main service	CPR during anesthesia emergence failure (emergency, not routine anesthesia service)

Example (Modifier 59 / XS):

Physician performs epidural steroid injection of the neck (62310) and injection of the shoulder joint (20610) on the same patient, same day.

62310 Epidural injection, cervical (primary)

20610-59 Aspiration/injection, major joint + Distinct Procedural Service

For Medicare billing, use 20610-XS (Separate Structure) instead of 59, since the services are at different anatomic sites.

Example (Modifier XE — Separate Encounter):

Physician performs diagnostic nasal endoscopy at 10 AM (31231). Patient returns to ER at 8 PM with severe epistaxis; complex anterior epistaxis control is performed (30903).

31231 Nasal endoscopy, diagnostic (10 AM)

```
30903-XE  Control nasal hemorrhage + Separate Encounter (8 PM
ER visit)
```

Modifier 62 — Two Surgeons

Under certain circumstances, the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. Each surgeon reports the same procedure code with modifier 62 appended. This modifier is used when two surgeons perform a single procedure TOGETHER, each acting as a primary surgeon performing a different aspect of a complex procedure.

KEY RULES

- Each surgeon is a PRIMARY surgeon performing a different aspect of the same complex procedure.
- Each surgeon must dictate their own operative report and identify the other as co-surgeon.
- Both surgeons submit claims for the SAME procedure code with modifier 62 appended.
- Do NOT use modifier 62 to describe the services of an assistant surgeon — use modifier 80 or 82.
- Modifier 62 may NOT be reported when THREE or more surgeons work together — use modifier 66 (Surgical Team).
- Submit a letter to the carrier detailing the reason two surgeons were required.

Example:

PEG tube placement. One physician performs the endoscopic component; the other performs the percutaneous component. Each has their own operative report.

```
43246-62  Esophagogastroduodenoscopy with directed submucosal
injection + Two Surgeons (Dr. A)
43246-62  Same code + Two Surgeons (Dr. B)
```

Surgeon Modifiers — Comprehensive Comparison

Modifier	Scenario	Number of Surgeons	Each Bills
62	Two primary surgeons perform different aspects of ONE complex procedure requiring both simultaneously	2 surgeons	Same CPT code + modifier 62
66	Surgical team of 3 or more surgeons perform a single highly complex procedure	3+ surgeons	Same CPT code + modifier 66
80	Full assistant surgeon present for entire/substantial portion of operation	2 surgeons (1 primary, 1 assistant)	Primary: no modifier. Assistant: same CPT + modifier 80
81	Minimum assistant — briefly needed during operation	2 surgeons (1 primary, 1 brief assistant)	Primary: no modifier. Assistant: same CPT + modifier 81
82	Assistant surgeon in teaching hospital — no qualified resident available	2 surgeons (1 primary, 1 assistant)	Primary: no modifier. Assistant: same CPT + modifier 82

Modifier 73 — Discontinued Outpatient Hospital/ASC Procedure Prior to 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 patient's surgical preparation (including sedation when provided and being taken to the procedure room), but PRIOR to the administration of anesthesia. The intended service can be reported by its usual procedure number with modifier 73.

KEY RULES

- Modifier 73 is for ASC/outpatient hospital facility use ONLY.
- For physician reporting of a discontinued procedure, use modifier 53 instead.
- Elective cancellations (before surgical preparation) should NOT be reported.

Modifier 74 — Discontinued Outpatient Hospital/ASC Procedure After Administration of Anesthesia

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

KEY RULES

- Modifier 74 is for ASC/outpatient hospital facility use ONLY.
- For physician reporting, use modifier 53.
- The procedure started but terminated is reported by its usual procedure number + modifier 74.

Modifier 78 — Unplanned Return to the Operating Room for a Related Procedure During the Postoperative Period

Modifier 78 is used to identify a related procedure requiring a return trip to the operating room on the same day as or within the postoperative period of a major or minor surgery, to treat the patient for complications resulting from the original surgery.

APPROPRIATE USAGE

- A related procedure (with a 000, 010, 090, YYY, or ZZZ global surgery indicator on the MPFSDB) requiring a return to the OR within the post-operative period.
- Treatment of complications resulting from the original surgery.
- When the procedure code used to describe treatment of complications is the SAME as the original procedure code, modifier 78 is still the correct modifier.

✕ DO NOT USE / COMMON PITFALLS

- Do NOT use modifier 78 for procedures performed outside the OR (patient's room, minor treatment room, recovery room, ICU).
- Do NOT use modifier 78 when the surgery is unrelated to the original procedure — use modifier 79 instead.

KEY RULES

- An OR for modifier 78 purposes includes: cardiac catheterization suite, laser suite, endoscopy suite. It does NOT include a patient's room, minor treatment room, recovery room, or ICU.
- A NEW postoperative period does NOT begin when using modifier 78.
- Modifier 78 allows for the intraoperative percentage only of major or minor procedures (010 or 090 global surgery indicators).

Modifier 79 — Unrelated Procedure by the Same Physician During the Postoperative Period

Modifier 79 describes an unrelated procedure performed during the post-operative period of the original procedure, by the same physician.

APPROPRIATE USAGE

- To describe an unrelated procedure performed during the post-operative period of the original procedure.
- The two procedures are performed by the SAME physician.
- Used on services during the post-operative period starting the DAY AFTER the original procedure.

✕ DO NOT USE / COMMON PITFALLS

- Do NOT use modifier 79 if the procedure performed is related to the original procedure or is a staged procedure — use modifier 58 or 78 as appropriate.
- A NEW global period DOES begin when modifier 79 is used.

Modifier 80 — Assistant Surgeon

Surgical assistant services are identified by adding modifier 80 to the usual procedure number. 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, the assisting physician reports the same surgical procedure as the operating surgeon. The

operating surgeon does NOT append a modifier. The assistant surgeon reports the same CPT® code with modifier 80 appended.

Example:

One physician harvests a saphenous vein graft; a different physician performs the CABG procedure (coronary artery bypass with two venous grafts, 33511).

```
33511     CABG using venous graft, single (operating surgeon
— no modifier)
33511-80  Same code + Assistant Surgeon (assistant who
harvested the vein graft)
```

Modifier 81 — Minimum Assistant Surgeon

Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number. This modifier is used when a primary operating physician planned to perform a procedure alone, but during the operation, circumstances arise that require the services of an assistant surgeon for a relatively short time.

Modifier 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. This modifier is used in teaching hospitals when a physician assistant surgeon is needed because no qualified resident surgeon is available.

CODING TIP

- For Medicare: Nurse practitioners (NP), physician assistants (PA), and clinical nurse specialists (CNS) assisting in surgery use modifier AS (assistant at surgery for non-physician providers). Modifier AS must be used in conjunction with modifier 80, 81, or 82.
- Each third-party payer may establish their own reporting guidelines for assistant surgeon services. Verify with each payer.

CHAPTER 5

Master Quick Reference Table — All CPT® Modifiers

CPT® Modifiers — Master Reference Table

Modifier	Name	Applied To	Key Rule	Global Period
22	Increased Procedural Services	Procedure code	Work substantially greater than typical; send special report	Any
23	Unusual Anesthesia	Procedure code	General anesthesia when none/local normally required	N/A
24	Unrelated E/M During Post-op	E/M code ONLY	E/M unrelated to surgery; same surgeon; post-op period only	0, 10, 90-day
25	Significant Separate E/M Same Day	E/M code ONLY	E/M separately identifiable; same day as MINOR procedure	0 or 10-day
26	Professional Component	Procedure code	Physician interpretation only; technical component billed separately	N/A
32	Mandated Services	Any service code	Service required by third party, insurer, court, or agency	N/A
33	Preventive Services	Procedure code	USPSTF A/B rated service; waives patient cost-sharing	N/A
47	Anesthesia by Surgeon	Surgical code	Regional/general anesthesia provided by operating surgeon	N/A
50	Bilateral Procedure	Procedure code	Same procedure on both sides at same session	N/A
51	Multiple Procedures	Additional procedure codes	Multiple procedures same session, same provider; highest RVU first	N/A
52	Reduced Services	Procedure code	Service partially reduced; procedure started but not completed electively	N/A

53	Discontinued Procedure	Procedure code	Procedure terminated due to patient risk AFTER anesthesia	N/A
54	Surgical Care Only	Surgical code	Surgeon performs surgery; another provider does pre/post care	90-day
55	Postoperative Management Only	Surgical code	Provider performs post-op care only; another did surgery	90-day
56	Preoperative Management Only	Surgical code	Provider performs pre-op care only; another did surgery	90-day
57	Decision for Surgery	E/M code ONLY	E/M leads to decision for MAJOR (90-day) surgery	90-day
58	Staged/Related Procedure During Post-op	Procedure code	Planned, staged, or related procedure during global period; starts NEW global	90-day
59	Distinct Procedural Service	Procedure code	Services distinct due to different site, session, or encounter; not on E/M	N/A
62	Two Surgeons	Procedure code (both)	Two primary surgeons each bill the same code; each needs op report	N/A
63	Procedure on Infant <4 kg	Surgery codes only (20005-69990)	Neonate/infant under 4 kg; replaces modifier 22 for these cases	N/A
66	Surgical Team	Procedure code (all)	Three or more surgeons work as a team on single CPT code	N/A
73	Discontinued ASC Procedure (pre-anesthesia)	Procedure code	ASC use ONLY; procedure stopped before anesthesia for patient risk	N/A
74	Discontinued ASC Procedure (post-anesthesia)	Procedure code	ASC use ONLY; procedure stopped after anesthesia for patient risk	N/A
78	Unplanned Return to OR (related)	Procedure code	Return to OR for complication of original surgery; NO new global period	0, 10, 90-day
79	Unrelated Procedure During Post-op	Procedure code	Unrelated procedure during global period; DOES start new global period	0, 10, 90-day
80	Assistant Surgeon	Procedure code	Full assistant for entire/substantial portion of surgery	N/A

81	Minimum Assistant Surgeon	Procedure code	Assistant needed briefly during procedure	N/A
82	Assistant Surgeon (no resident available)	Procedure code	Teaching hospital; no qualified resident surgeon available	N/A
90	Reference (Outside) Laboratory	Lab code	Lab performed by outside party, not treating/reporting provider	N/A
91	Repeat Clinical Diagnostic Lab Test	Lab code	Same lab repeated same day for subsequent results; not for re-runs	N/A
92	Alternative Lab Platform Testing	Lab code	Single-use, disposable analytical chamber (e.g., portable HIV kit)	N/A
99	Multiple Modifiers	Procedure code	Two or more modifiers needed; list 99 first, then all applicable modifiers	N/A
XE	Separate Encounter (X modifier)	Procedure code	Distinct service at a separate encounter	N/A
XP	Separate Practitioner (X modifier)	Procedure code	Distinct service by a different practitioner	N/A
XS	Separate Structure (X modifier)	Procedure code	Distinct service on a separate organ/structure	N/A
XU	Unusual Non-Overlapping Service (X modifier)	Procedure code	Service does not overlap usual components of main service	N/A

CHAPTER 6

20 Specialty Exam-Style Questions with Answers & Explanations

CPT® Modifier — Specialty Exam Practice Questions

> *"The best preparation for a specialty coding exam is not memorization — it is mastering the clinical reasoning that drives modifier selection. Every modifier question tests one core skill: does the documentation support this specific circumstance?"*
>
> **— Medesun Global — CPT® Exam Preparation Strategy**

Question #1: A surgeon performed a total abdominal hysterectomy (58150) on a 42-year-old female for dysfunctional uterine bleeding. When he opened the abdomen, he found extensive adhesions from three prior cesarean sections, requiring more than one extra hour of work. What is the appropriate modifier to append to code 58150?

a) Modifier 52
b) Modifier 78
c) Modifier 22
d) Modifier 74

Answer: C — Modifier 22: Increased Procedural Services
Explanation: *The work required was substantially greater than typically required due to extensive adhesions. Modifier 22 is appropriate when the procedure is significantly more complex than usual. The surgeon must submit a special report documenting the additional time and circumstances.*

Question #2: A 17-year-old male came to the ED with acute right lower abdominal pain. The physician diagnosed acute appendicitis and decided to perform emergency surgery. What is the appropriate modifier to append to E/M code 99285?

a) Modifier 25
b) Modifier 62
c) Modifier 58
d) Modifier 57

Answer: D — Modifier 57: Decision for Surgery
Explanation: *The E/M service in the ED directly resulted in the initial decision to perform a major surgical procedure (appendectomy, 90-day global period). Modifier 57 is appended to the E/M code, not the surgical code. Modifier 25 would be incorrect because the surgery is major (90-day global).*

Question #3: An ophthalmologist removed a foreign body from the cornea of a 3-year-old under general anesthesia. The physician documented that the patient was not cooperating for the procedure under local anesthesia, thus necessitating general anesthesia. What is the appropriate modifier to append to code 65220?

a) Modifier 23
b) Modifier 22
c) Modifier 51
d) Modifier 25

Answer: A — Modifier 23: Unusual Anesthesia
Explanation: *Corneal foreign body removal (65220) is normally performed under local or no anesthesia in adults. Because of the unusual circumstance (uncooperative 3-year-old patient requiring general anesthesia), modifier 23 is appropriate. The medical necessity is clearly documented.*

Question #4: A surgeon removed 4 skin tags by electrosurgical destruction. During the same session, the patient complained of epigastric pain. The physician documented an expanded problem focused history, examination, and low complexity MDM, and prescribed medication for mild gastritis. What modifier should be appended to E/M code 99212?

a) Modifier 22
b) Modifier 25
c) Modifier 23

d) Modifier 51

Answer: B — Modifier 25: Significant, Separately Identifiable E/M Service

Explanation: *The physician performed a minor procedure (skin tag removal, 0/10-day global) AND a separately identifiable E/M for a different complaint (gastritis) on the same day. Modifier 25 is appended to the E/M code 99212 to indicate it is a significant, separately identifiable service above and beyond the pre/post-service work of the skin tag removal.*

Question #5: A 52-year-old male patient was given an E/M service of level 4 (99214) for acute cholecystitis by his surgeon. The patient had prostatectomy surgery by the same surgeon 42 days before. The insurer refused to pay for the E/M. What modifier should have been appended?

a) Modifier 24
b) Modifier 25
c) Modifier 26
d) Modifier 22

Answer: A — Modifier 24: Unrelated E/M During Postoperative Period

Explanation: *The patient is within the 90-day global period of the prostatectomy. The visit for acute cholecystitis is unrelated to the original prostatectomy. Modifier 24 must be appended to the E/M code to inform the payer that this visit is for an unrelated condition during the post-operative period, making it separately reimbursable.*

Question #6: A 36-year-old male prisoner was referred to a gastroenterologist's office by the state for evaluation of jaundice. The physician performed a level 4 service. What modifier should be appended to E/M code 99244?

a) Modifier 51
b) Modifier 52
c) Modifier 50
d) Modifier 32

Answer: D — Modifier 32: Mandated Service

Explanation: *The patient was referred by a state agency (mandated service). Modifier 32 is used when a service is required by a third party such as a court, insurance carrier, state agency, or peer review organization. This modifier alerts the claim processor that special handling is needed.*

Question #7: A 32-year-old female with 3-week amenorrhea presented to the ED for severe right lower abdominal pain. The physician diagnosed tubal pregnancy and performed emergency laparoscopic treatment of ectopic pregnancy (59150). No anesthetist was available so the gynecologist administered spinal anesthesia. What modifiers are appropriate for codes 99285 and 59150 respectively?

a) 99285-25, 59150-47
b) 99285-47, 59151-25
c) 99285-47, 59150-25
d) 99285-57, 59150-47

Answer: D — 99285-57 (Decision for Surgery) and 59150-47 (Anesthesia by Surgeon)
Explanation: *The E/M service in the ED led to the decision to perform major surgery (59150 has a 90-day global period), so modifier 57 is appended to 99285. The gynecologist personally administered spinal anesthesia because no anesthetist was available, so modifier 47 (Anesthesia by Surgeon) is appended to the surgical code 59150.*

Question #8: A physician performed correction of inverted nipples bilaterally (19355) on an 18-year-old female patient. What modifier should be appended to code 19355?

a) Modifier 51
b) Modifier 52
c) Modifier 50
d) Modifier 59

Answer: C — Modifier 50: Bilateral Procedure
Explanation: *The same procedure (correction of inverted nipples) was performed on both sides of the body at the same session. Modifier 50 identifies this as a bilateral procedure. This is not a naturally bilateral code by definition, so modifier 50 must be appended.*

Question #9: A physician removed 2 skin tags (one from neck, one from armpit) and excised a benign cystic lesion (2.9 cm) from scrotal skin with simple closure. What modifiers (if any) should be appended to codes 11200 and 11423?

a) 11200-51, 11200-51, 11423-57
b) 11200, 11423
c) 11200-25, 11423-51
d) 11200, 11423-51

Answer: D — 11200 (no modifier), 11423-51 (Multiple Procedures)
Explanation: *Code 11200 (skin tag removal) is the primary procedure reported first without a modifier. Code 11423 (excision benign lesion 2.1-3.0 cm) is a separate, additional procedure performed at the same session and is therefore reported with modifier 51 to indicate it is a secondary procedure. Modifier 51 is not placed on 11200 as it is the primary (highest value) procedure.*

Question #10: A 24-year-old female presented to the ED with swelling and pain over the left forearm after a fall. The orthopedist ordered X-ray of the forearm (2 views) and interpreted the films himself. He diagnosed fracture of the left ulna shaft. What modifier should be appended to code 73090?

a) Modifier 51
b) Modifier 52
c) Modifier 54
d) Modifier 26

Answer: D — Modifier 26: Professional Component
Explanation: *The orthopedist ordered and interpreted the X-ray (professional component only) but did not own the X-ray equipment. The facility performed the technical component separately. Modifier 26 is appended to 73090 to indicate the physician is billing only for the professional (interpretation) component of the radiology service.*

Question #11: The same orthopedist from Question 10 performed closed reduction of the fracture and then repeated the same X-ray (2

views) to verify alignment. What modifier should be appended to the repeated X-ray?

a) Modifier 77
b) Modifier 74
c) Modifier 76
d) No modifier

Answer: C — Modifier 76: Repeat Procedure by Same Physician
Explanation: *The same physician repeated the exact same X-ray on the same day to verify alignment post-reduction. Modifier 76 is appended to the second X-ray code to prevent the claim from being rejected as a duplicate. Modifier 77 would be used if a DIFFERENT physician repeated the same procedure.*

Question #12: A 65-year-old male scheduled for diagnostic indirect laryngoscopy with biopsy (31510) at a physician's office was given anesthesia. During the procedure, the patient developed severe cough and the physician discontinued the procedure due to patient safety concerns. What modifier should be appended to code 31510?

a) Modifier 32
b) Modifier 73
c) Modifier 74
d) Modifier 53

Answer: D — Modifier 53: Discontinued Procedure
Explanation: *The procedure was terminated after anesthesia was administered due to an unexpected circumstance threatening patient well-being (severe cough). Modifier 53 is used for physician reporting of a discontinued procedure in any setting. Note: Modifiers 73 and 74 are for ASC/outpatient hospital FACILITY use only — not for physician professional billing.*

Question #13: A 14-year-old female was treated by an ENT surgeon for a secondary tonsil which regrew 6 years after primary tonsillectomy and adenoidectomy. The surgeon performed tonsillectomy on the left side only. What modifier should be appended to code 42826?

a) Modifier 51

b) Modifier 52
c) Modifier 53
d) Modifier 22

Answer: B — Modifier 52: Reduced Services
Explanation: *Code 42826 describes tonsillectomy for age 12 and over (bilateral by implication). Since only one side (left) was treated, the service was reduced. Modifier 52 indicates the service was partially reduced without disturbing the identification of the basic code. Modifier 53 is incorrect because the procedure was not discontinued — it was completed, just on one side only.*

Question #14: Patient was scheduled for external hemorrhoidectomy (46250) on 10/12. Dr. A was busy with an emergency so he arranged with Dr. B for preoperative management on 10/11. Dr. A performed the surgery as scheduled. What modifier should be appended to code 46250 for Dr. B's services?

a) Modifier 55
b) Modifier 56
c) Modifier 54
d) Modifier 52

Answer: B — Modifier 56: Preoperative Management Only
Explanation: *Dr. B provided ONLY the preoperative management (evaluation the day before surgery). Modifier 56 identifies preoperative care provided by a physician other than the surgeon. Dr. A would report 46250-54 (Surgical Care Only) since Dr. A performed the surgery but not the preoperative care.*

Question #15: Patient was scheduled for fistulectomy (46275) at an ASC. Dr. A visits the ASC only once per week on Saturdays. He performed the surgery only; pre- and postoperative care was provided by another physician. What modifier should be appended to code 46275 for Dr. A's services?

a) Modifier 52
b) Modifier 54
c) Modifier 56
d) Modifier 58

Answer: B — Modifier 54: Surgical Care Only
Explanation: *Dr. A performed the surgical procedure only. Pre- and postoperative care was provided by another physician. Modifier 54 (Surgical Care Only) is appended to indicate that Dr. A is billing only for the intraoperative component of the global surgical package.*

Question #16: Dr. A performed laparoscopic appendectomy (44970) on 12/11 and immediately traveled out of town for a medical conference. Dr. B provided postoperative care. What modifier should be appended to code 44970 for Dr. B's services?

a) Modifier 55
b) Modifier 54
c) Modifier 56
d) Modifier 58

Answer: A — Modifier 55: Postoperative Management Only
Explanation: *Dr. B is providing ONLY the postoperative care. Modifier 55 is appended to the surgical code 44970 by Dr. B to indicate postoperative management only. Dr. A would report 44970-54 (Surgical Care Only).*

Question #17: A patient has left renal calculus and a large bladder calculus. On 12/1, Dr. A performed ESWL (50590) on the renal calculus. On 12/20, Dr. A performed cystolithotomy (51050) to remove the bladder calculus. Both procedures are related and were planned with a 20-day interval. What modifier should be appended to the second procedure 51050?

a) Modifier 55
b) Modifier 78
c) Modifier 58
d) Modifier 24

Answer: C — Modifier 58: Staged or Related Procedure During Postoperative Period
Explanation: *The cystolithotomy (51050) is a related, planned (staged) procedure performed during the global period of the ESWL (50590). Modifier 58 indicates the second procedure was planned/staged*

at the time of the original procedure. This modifier starts a new global period for the second procedure.

Question #18: The physician removes 7 skin tags (11200) and excises a benign skin lesion 2 cm from the left shin (11402) with intermediate closure (12031) and destroys one premalignant lesion by cryosurgery on the left shin (17000) at the same session. What modifier should be appended to the 2nd, 3rd, and 4th codes?

a) Modifier 52
b) Modifier 59
c) Modifier 51
d) Modifier 50

Answer: C — Modifier 51: Multiple Procedures
Explanation: *Multiple distinct procedures are performed at the same session by the same physician. The primary procedure (highest RVU, 11200) is listed first without a modifier. All additional procedures (11402, 12031, 17000) are reported with modifier 51 to indicate they are secondary procedures in a multiple-procedure scenario.*

Question #19: A pediatric surgeon performed emergency colostomy (44320) on a newborn baby of 3.5 kg with imperforate anus. The baby had not passed meconium 3 days after birth. What modifier should be appended to code 44320?

a) Modifier 62
b) Modifier 66
c) Modifier 22
d) Modifier 63

Answer: D — Modifier 63: Procedure Performed on Infant less than 4 kg
Explanation: *The baby weighs 3.5 kg, which is under the 4 kg threshold for modifier 63. Procedures on neonates and infants under 4 kg involve significantly increased complexity and physician work. Code 44320 is in the Surgery section (20005–69990), so modifier 63 is applicable. Note: Modifier 63 replaces modifier 22 for infants under 4 kg.*

Question #20: A 26-year-old male with cervical fractures at C4-C5 had two primary surgeons perform open reduction (22326, 22328) and arthrodesis C3-C6 (22600, 22614 x3) together. What modifier should be appended to the services of both surgeons?

a) Modifier 56
b) Modifier 55
c) Modifier 62
d) Modifier 54

Answer: C — Modifier 62: Two Surgeons

Explanation: *Two primary surgeons worked together simultaneously on the same complex spinal procedure, each performing a distinct portion requiring their individual expertise. Modifier 62 is appended to the procedure codes for BOTH surgeons. Each surgeon bills the same CPT® codes with modifier 62 and submits their own operative report. The carrier must be notified of the co-surgery arrangement.*

CHAPTER 7

Ethics • Compliance • Specialty Exam Strategy • URL References

Ethics in Modifier Usage

> *"A modifier is a declaration to the payer. It states: 'The circumstances of this service differ from the standard, and here is how.' That declaration must be truthful, documented, and clinically defensible. Modifiers used without documentation are not modifiers — they are false claims."*
>
> **— Medesun Global — AMA CPT® Ethics Framework**

ETHICS IN MEDICAL CODING

- Every modifier appended to a claim must be supported by corresponding documentation in the medical record. There are no exceptions.
- Modifier 25 (significant, separate E/M) is one of the OIG's top audit targets. The E/M service must be fully and separately documented with its own history, examination, and medical decision making.
- Modifier 59 / X{EPSU}: Never append these modifiers solely to bypass NCCI bundling edits without true clinical justification. Doing so without documentation constitutes fraud under the False Claims Act (31 U.S.C. § 3729).
- Modifier 22 (Increased Procedural Services): Appending modifier 22 routinely to inflate reimbursement — without specific documentation of substantially greater work — is a billing compliance violation.
- Split-care modifiers (54/55/56): Both physicians must document the formal transfer of care agreement. Billing for postoperative care by one physician while another actually provides it is fraud.
- Modifier 57 (Decision for Surgery): This modifier requires that the E/M visit genuinely resulted in the initial decision to perform surgery. If the surgery was already scheduled before the visit, the E/M is included in the global package.

- Maintain current knowledge: Modifier policies, NCCI edits, and CMS guidelines change annually. Coders have an ethical obligation to use the most current references.
- Report suspected modifier abuse through your organization's compliance program. The False Claims Act protects whistleblowers from retaliation.

Specialty Exam — Master Strategy

SPECIALTY EXAM TIPS

- TAB YOUR MANUAL: Before any specialty exam, tab Appendix A (Modifiers), Appendix D (Add-on Codes), and Appendix E (Modifier 51 Exempt Codes) in your CPT® manual.
- THE FIVE MOST TESTED MODIFIER PAIRS: (1) 24 vs. 25 vs. 57, (2) 52 vs. 53, (3) 54/55/56 (split care), (4) 58 vs. 78 vs. 79, (5) 62 vs. 66 vs. 80/81/82.
- E/M ONLY RULE: Modifiers 24, 25, and 57 go on E/M codes ONLY. If an answer choice shows these on a procedure code, eliminate it immediately.
- PROCEDURE CODE ONLY RULE: Modifiers 54, 55, 56, 58, 62, 66, 78, 79, 80, 81, 82 go on procedure codes, NOT E/M codes.
- ASC ONLY RULE: Modifiers 73 and 74 are for ASC/outpatient hospital FACILITY use only. Modifier 53 is for physician use.
- GLOBAL PERIOD MAPPING: Before answering any post-op modifier question, determine: Same day? During global period? Related or unrelated? Return to OR or not?
- MODIFIER 50 TRAP: If the code descriptor already says 'bilateral,' do NOT add modifier 50.
- MODIFIER 51 TRAP: Never add modifier 51 to add-on codes (Appendix D) or modifier 51-exempt codes (Appendix E).
- MODIFIER 59 / X{EPSU}: Know that XE, XP, XS, XU are more specific subsets of modifier 59, introduced January 1, 2015. For Medicare, prefer X modifiers when applicable.
- TIME MANAGEMENT: Modifier questions are among the fastest to answer if you know the rules. Do not spend more than 90 seconds on any modifier question. Mark and return if uncertain.
- OPEN BOOK ADVANTAGE: If uncertain, go directly to Appendix A in your CPT® manual. The definition is there. Read the exact language — exam questions frequently quote directly from it.

✕ TOP 8 MODIFIER MISTAKES ON SPECIALTY EXAMS — AND HOW TO AVOID THEM

- Applying modifier 25 to a major procedure (90-day global) instead of modifier 57. FIX: Always check the global period first. 90-day = modifier 57. 0 or 10-day = modifier 25.
- Appending E/M modifiers (24, 25, 57) to surgical codes. FIX: These three modifiers ALWAYS go on the E/M code, never the procedure code.
- Using modifier 73/74 for physician billing instead of modifier 53. FIX: 73 and 74 are ASC/facility only. Physicians use modifier 53.
- Adding modifier 50 to inherently bilateral codes. FIX: Check the CPT® descriptor. If it says 'bilateral,' do not add modifier 50.
- Adding modifier 51 to add-on codes. FIX: Check Appendix D. If the code is listed there, no modifier 51.
- Confusing modifier 58 (staged, related — starts new global) with modifier 78 (complication, related — NO new global). FIX: 78 = complication, no new global. 58 = planned/staged, new global starts.
- Using modifier 62 when the scenario describes an assistant surgeon. FIX: Modifier 62 = two PRIMARY surgeons co-operating. Modifier 80/81 = one primary + one assistant.
- Using modifier 26 when the physician provides both components. FIX: Modifier 26 = professional component only. If physician owns equipment AND interprets, report global code with NO modifier.

URL References & Resources

Resource	URL / Reference
AMA CPT® Professional Edition (annual)	www.ama-assn.org/practice-management/cpt
AMA CPT® Appendix A — Modifiers	CPT® manual, Appendix A (included in every edition)
CMS Medicare Physician Fee Schedule (MPFS)	www.cms.gov/apps/physician-fee-schedule/

CMS NCCI Policy Manual for Medicare Services	www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/
CMS — How to Use NCCI Tools	www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Policy-Manual
CMS Internet Only Manual — Global Surgery (Chapter 12)	www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs
US Preventive Services Task Force (USPSTF) A/B Ratings	www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
AAPC — Modifier 59 and X{EPSU} Guidance	www.aapc.com/codes/modifier-codes/
AAPC Code of Ethics	www.aapc.com/about/ethics.aspx
OIG Work Plan — Modifier Audit Targets	oig.hhs.gov/reports-and-publications/workplan/
Medesun Global — Medical Coding Training	www.medesunglobal.com

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