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# Understanding CURRENT PROCEDURAL TERMINOLOGY & HCPCS Coding Systems

# 2021

**Mary Jo Bowie**
MS, BS, AAS, RHIA, RHIT

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# CURRENT PROCEDURAL TERMINOLOGY AND HCPCS
# Coding Systems

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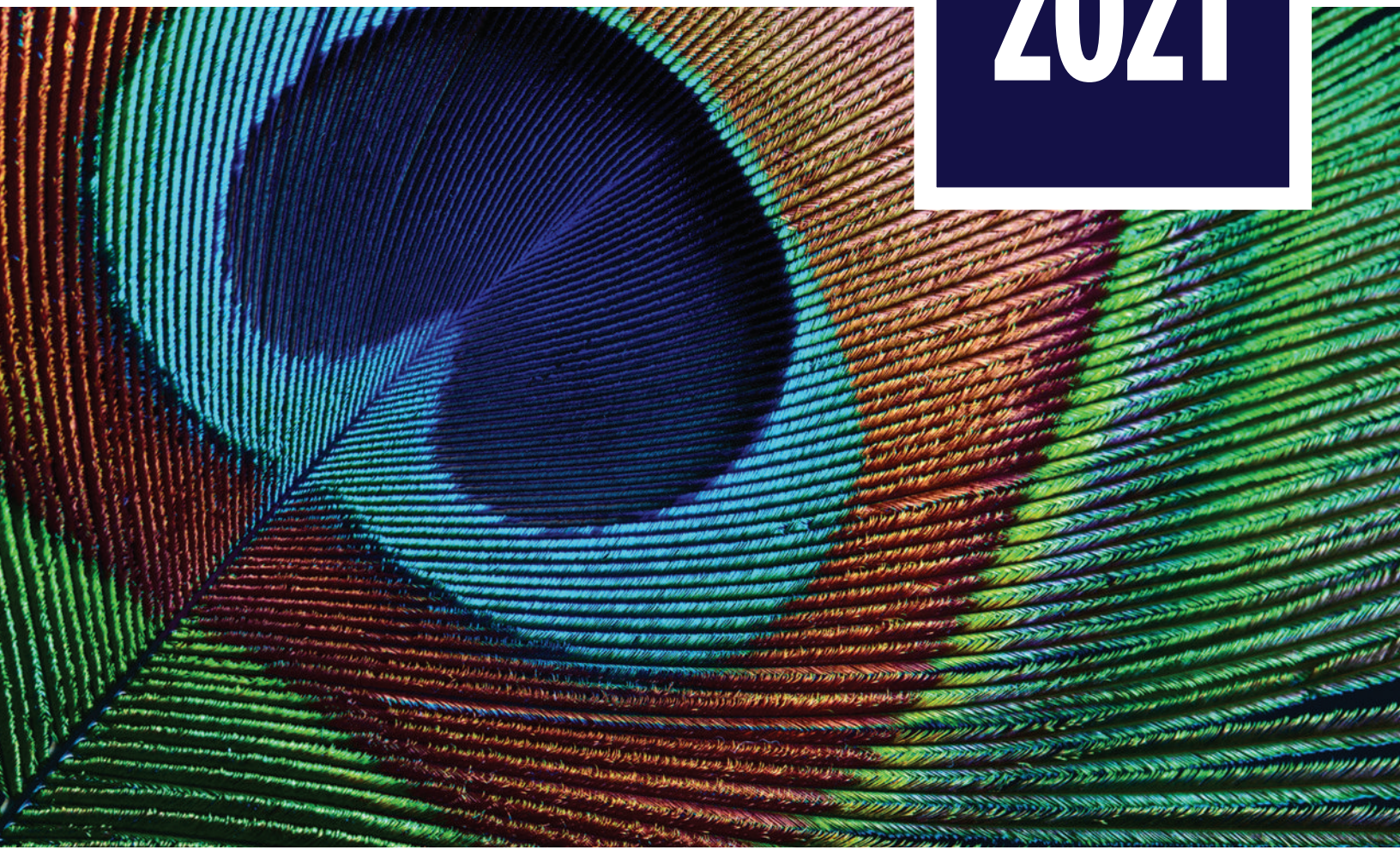


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***Understanding Current Procedural Terminology and HCPCS Coding Systems*, 2021 edition**
**Mary Jo Bowie**

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# TABLE OF CONTENTS

# PREFACE

*Understanding Current Procedural Terminology and HCPCS Coding Systems* represents a comprehensive approach to learning and mastering procedural coding. This book provides detailed instruction for CPT coding as well as additional resource information that is essential for coders. This book can be used in an academic setting and also as a reference in a working environment. Space has been provided in the text for the learner to work on exercises to promote a hands-on approach to coding.

This book approaches procedural coding in a fresh and innovative manner. Many clinical examples are used throughout the text to provide the student with real-life coding examples and practice. The book also provides a review of human anatomy that is relevant to selecting procedural codes. Learning is reinforced by the use of illustrations of anatomy and operative procedures.

## New to the 2021 Edition

The 1995 and 1997 Documentation Guidelines for Evaluation and Management Services are available at the CMS website at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf and https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf, respectively.

- The textbook, MindTap, and Instructor's Manual have been updated to include the most current code sets available at the time of publication.
- Additional Coding Assignments have been added in many chapters.

## Organization of the Text

*Understanding Current Procedural Terminology and HCPCS Coding Systems* has 23 chapters, which present an introduction to CPT coding and detail on all of the main sections of CPT. Each chapter contains Internet links, a summary, and a chapter review to facilitate learning. Case studies are used throughout the text to enrich the learning process.

## Special Features of the Text

Several features are incorporated into the chapters to facilitate learning:

- **Chapter outlines** located at the beginning of each chapter help organize the material.
- **Learning objectives** establish goals for each chapter and can be used as a checklist for reviewing concepts.
- **Key terms** are identified at the beginning of the chapter, are boldfaced throughout the chapter, and appear in the glossary to assist readers in learning the technical vocabulary associated with coding.
- **Exercises** challenge the learner's knowledge and reinforce understanding of presented materials.
- **Examples** illustrate key concepts to promote understanding.
- **Illustrations** of human anatomy and procedures appear throughout the book. These help the student visualize operative procedures and are a valuable resource for coders.
- **Internet links** encourage users to expand their knowledge and stay current with the most up-to-the-minute information.
- **Coding assignments** require learners to assign codes using coding manuals.
- **Case studies** encourage readers to apply concepts taught within the text to actual clinical scenarios.

# Learning Package for the Student

## MindTap

MindTap is the first of its kind in an entirely new category: the Personal Learning Experience (PLE). This personalized program of digital products and services uses interactivity and customization to engage students, while offering a range of choice in content, platforms, devices, and learning tools. MindTap is device agnostic, meaning that it will work with any platform or learning management system, and will be accessible anytime, anywhere: on desktops, laptops, tablets, mobile phones, and other Internet-enabled devices. *Understanding Current Procedural Terminology and HCPCS Coding Systems,* 2021 edition, on MindTap includes:

- An interactive eBook with highlighting, note-taking functions, and more
- Flashcards for practicing chapter terms
- Computer-graded activities and exercises
- Case studies
- Medical Coding Trainer

# Teaching Package for the Instructor

## Instructor Resources

The Companion Site contains a variety of tools to help instructors successfully prepare lectures and teach within this subject area. This comprehensive package provides something for all instructors, from those teaching coding for the first time to seasoned instructors who want something new. The following components in the website are free to adopters of the text:

- A downloadable, customizable *Instructor Manual* containing a complete list of chapter activities and assessments, additional activities and assignments, and a list of additional resources.
- A downloadable, customizable *Solution and Answer Guide* containing the answers for all textbook questions.
- A *Test Bank* with several hundred questions and answers for use in instructor-created quizzes and tests.
- Chapter slides created in *PowerPoint*® to use for in-class lecture material and as handouts for students.

## MINDTAP

On the MINDTAP platform in the new *Understanding Current Procedural Terminology and HCPCS Coding Systems,* 2021 edition, instructors customize the learning path by selecting Cengage resources and adding their own content via apps that integrate into the MINDTAP framework seamlessly with many learning management systems. The guided learning path demonstrates the relevance of basic principles in coding through engagement activities, interactive exercises, and animations, elevating the study by challenging students to apply concepts to practice. To learn more, visit www.cengage.com/mindtap.

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- reducing required storage space and paper.

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- ICD-10 mapping tools
- Coders' Desk Reference
- Complete code history
- Local Coverage Determinations (LCDs) and Medicare Pub. 100 access
- Medicare CCI edits
- Modifier crosswalk
- Enhanced compliance editor
- Enhanced LCD/NCD policy searching
- Cross-coder relationships from seven coding and billing specialty reference books

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# About the Author

## Mary Jo Bowie, MS, BS, AAS, RHIA, RHIT

Consultant and Owner, Health Information Professional Services, Binghamton, New York. Active member, American Health Information Management Association (AHIMA). Mary Jo has over 35 years experience in the health information and coding profession. Professionally she has served the New York State Health Information Management Association as Education Director and was a member of the Board of Directors, 1989–1991; Ambulatory Care Coding Guidelines (ACGC) Committee, 1995–2001; and was Chairperson of the ACGC Committee, 1993–1995. She was the New York State Nominee for the American Health Information Management Association National Award for Literary Contribution to Profession, 1993 and 1994. Mary Jo has completed numerous national professional seminars on ICD-9-CM, ICD-10-CM, and CPT coding. She was the lead trainer for Cengage Learning's ICD-10-CM Peer-to-Peer Training. She is an AHIMA-approved trainer for ICD-10-CM/PCS.

# Dedication

To my husband Bill, who is always by my side no matter what we face together, you are my motivation for all I do. To my daughter Sarah, and daughter Bethannie, son-in-law Jesse, and grandchildren Isabella, Jesse, Adelyn and Deklyn. My love is always with you. To my parents, who are always there to support everything I do.

In memory of Ted Bowie, who taught us all to fight until we hear the referee blow the whistle.

A special thanks to Kaitlin Schlicht, Stephen Smith, and Mark Peplowski, who keep me on track and make authoring a joy. To my extended Cengage family, thanks for all the work you do in marketing and promoting my books. A very special thanks to Lou Ann Decker for her time and work that she put into reviewing these pages and attaching the hot pink notes!

*—Mary Jo Bowie*

# Acknowledgments

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Holmes Community College
Ridgeland, Mississippi

Susan Long
Instructor
Bladen Community College
Dublin, North Carolina

# HOW TO USE THE TEXTBOOK

## Chapter Outline

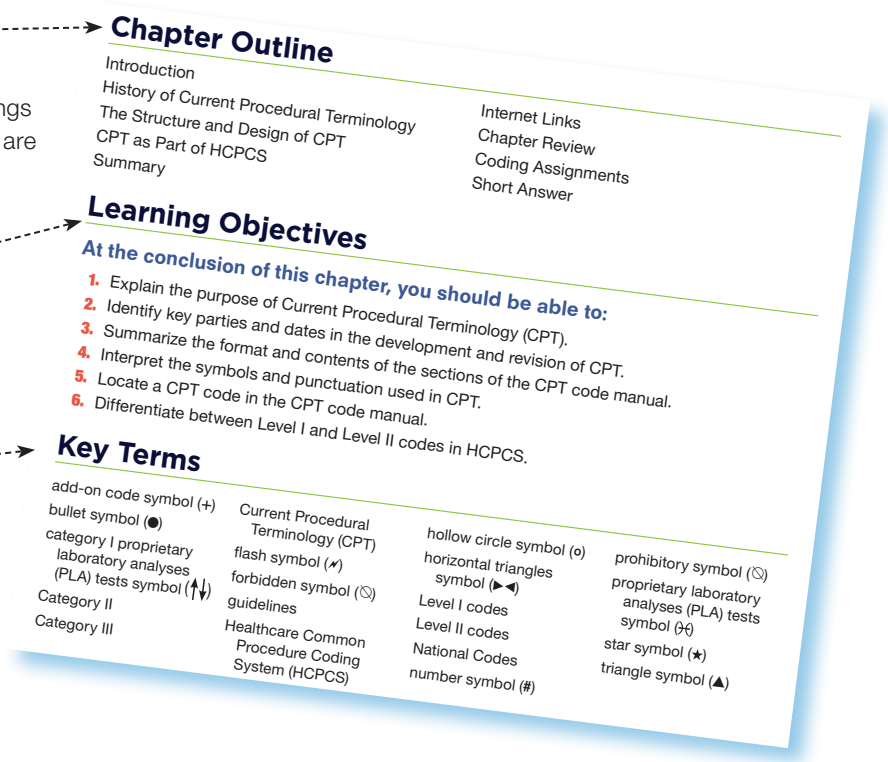
At the beginning of each chapter, you will find an outline of all major headings. Review these headings of topic areas before you study the chapter. They are a road map.

## Learning Objectives

Learning Objectives provide a framework for study of the chapter content.

## Key Terms

Key Terms represent new vocabulary that is highlighted within the chapter at first usage. Use the end-of-book Glossary to study definitions of all key terms.



### Chapter Outline

Introduction
History of Current Procedural Terminology
The Structure and Design of CPT
CPT as Part of HCPCS
Summary
Internet Links
Chapter Review
Coding Assignments
Short Answer

### Learning Objectives

**At the conclusion of this chapter, you should be able to:**

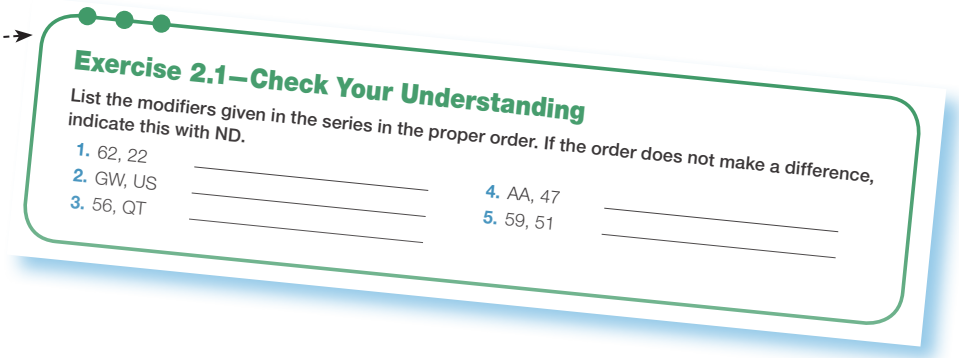
1. Explain the purpose of Current Procedural Terminology (CPT).
2. Identify key parties and dates in the development and revision of CPT.
3. Summarize the format and contents of the sections of the CPT code manual.
4. Interpret the symbols and punctuation used in CPT.
5. Locate a CPT code in the CPT code manual.
6. Differentiate between Level I and Level II codes in HCPCS.

### Key Terms

add-on code symbol (+)
bullet symbol (●)
category I proprietary laboratory analyses (PLA) tests symbol (▲)
Category II
Category III
Current Procedural Terminology (CPT)
flash symbol (⌁)
forbidden symbol (⃠)
guidelines
Healthcare Common Procedure Coding System (HCPCS)
hollow circle symbol (o)
horizontal triangles symbol (►◄)
Level I codes
Level II codes
National Codes
number symbol (#)
prohibitory symbol (⃠)
proprietary laboratory analyses (PLA) tests symbol (⌀)
star symbol (★)
triangle symbol (▲)

## Exercises

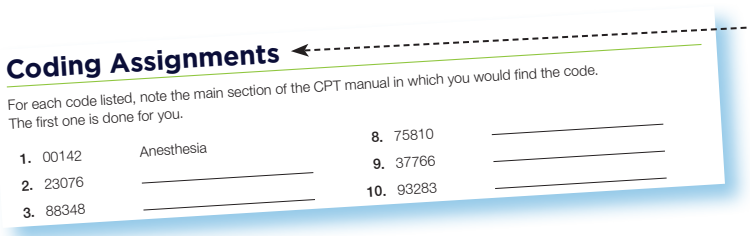
Sprinkled throughout the chapters, Exercises encourage readers to stop periodically and apply critical thinking skills to solve coding challenges.



### Exercise 2.1—Check Your Understanding

**List the modifiers given in the series in the proper order. If the order does not make a difference, indicate this with ND.**

1. 62, 22 _____
2. GW, US _____
3. 56, QT _____
4. AA, 47 _____
5. 59, 51 _____



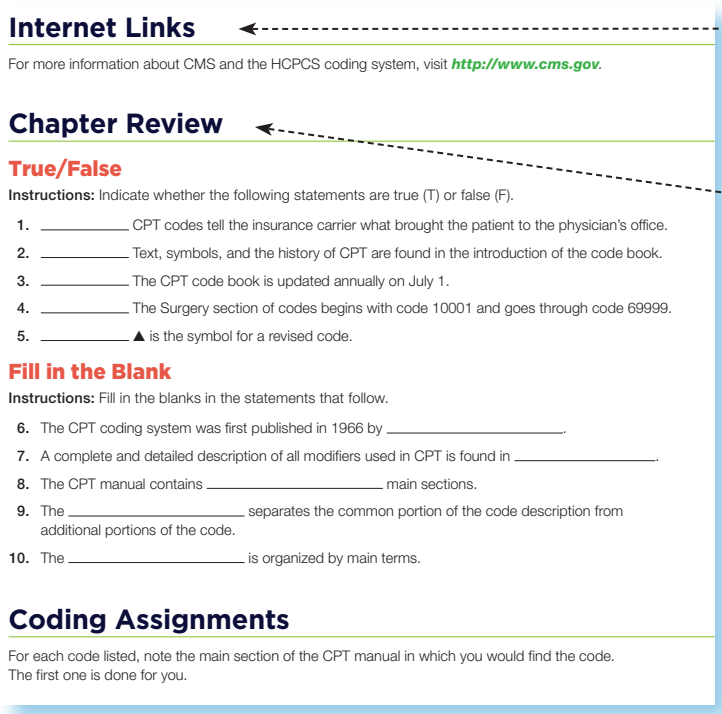
### Coding Assignments

For each code listed, note the main section of the CPT manual in which you would find the code. The first one is done for you.

1. 00142 Anesthesia
2. 23076 _____
3. 88348 _____
8. 75810 _____
9. 37766 _____
10. 93283 _____

## Coding Assignments

Coding Assignments invite you to use CPT and HCPCS coding manuals to identify proper procedural codes.



## Internet Links

For more information about CMS and the HCPCS coding system, visit ***http://www.cms.gov***.

## Chapter Review

### True/False

**Instructions:** Indicate whether the following statements are true (T) or false (F).

1. _____ CPT codes tell the insurance carrier what brought the patient to the physician's office.
2. _____ Text, symbols, and the history of CPT are found in the introduction of the code book.
3. _____ The CPT code book is updated annually on July 1.
4. _____ The Surgery section of codes begins with code 10001 and goes through code 69999.
5. _____ ▲ is the symbol for a revised code.

### Fill in the Blank

**Instructions:** Fill in the blanks in the statements that follow.

6. The CPT coding system was first published in 1966 by _____.
7. A complete and detailed description of all modifiers used in CPT is found in _____.
8. The CPT manual contains _____ main sections.
9. The _____ separates the common portion of the code description from additional portions of the code.
10. The _____ is organized by main terms.

## Coding Assignments

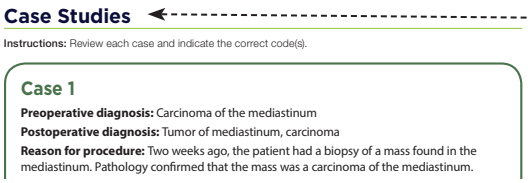
For each code listed, note the main section of the CPT manual in which you would find the code. The first one is done for you.

### Internet Links

Internet Links encourage you to expand your knowledge base with the most up-to-date information available on the Web.

### Chapter Review

Chapter Review sections appear in every chapter, and test your understanding of the material through questions in varying formats.



## Case Studies

**Instructions:** Review each case and indicate the correct code(s).

### Case 1

**Preoperative diagnosis:** Carcinoma of the mediastinum
**Postoperative diagnosis:** Tumor of mediastinum, carcinoma
**Reason for procedure:** Two weeks ago, the patient had a biopsy of a mass found in the mediastinum. Pathology confirmed that the mass was a carcinoma of the mediastinum.

### Case Studies

Case Studies challenge you to carefully select codes appropriate to the scenarios described.

# Introduction to Current Procedural Terminology

CHAPTER 1

## Chapter Outline



## Learning Objectives

### At the conclusion of this chapter, you should be able to:

1. Explain the purpose of Current Procedural Terminology (CPT).
2. Identify key parties and dates in the development and revision of CPT.
3. Summarize the format and contents of the sections of the CPT code manual.
4. Interpret the symbols and punctuation used in CPT.
5. Locate a CPT code in the CPT code manual.
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## Key Terms

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forbidden symbol (⃠)
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hollow circle symbol (o)
horizontal triangles symbol (►◄)
Level I codes
Level II codes
National Codes
number symbol (#)
prohibitory symbol (⃠)
proprietary laboratory analyses (PLA) tests symbol (⌀)
star symbol (★)
triangle symbol (▲)

## Introduction

The coding system known as **CPT**, or **Current Procedural Terminology**, was developed by the American Medical Association (AMA). The AMA annually updates the code sets within CPT, and the new codes become effective on January 1 of each year. These five-digit codes are part of the language used by physicians and

insurance companies to convey the services provided to a patient during an encounter. Just as the ICD-10-CM diagnostic codes explain what brought the patient to the provider for the encounter, CPT tells the insurance carrier what service or services were provided to the patient during that encounter.

The biggest hurdle that a coder might have with CPT coding is translating the physician's terminology or documentation into a billable service. Physicians communicate in medical terminology, whereas insurance carriers communicate in reimbursement language (CPT). For this reason, a working knowledge of CPT coding is necessary for the correct coding of procedures and services. Insurance carriers require that CPT codes be submitted on claims to determine the appropriate payment for the services rendered.

This chapter will provide an overview of the CPT manual as well as the terms and symbols used to guide coders to the proper selection of CPT codes. The CPT manual is officially titled Current Procedural Terminology Codebook. However it is commonly known as the CPT manual or the CPT code book.

# History of Current Procedural Terminology

The CPT coding system was first published in 1966 by the AMA. The system provided uniform reporting of physician services performed in the outpatient setting. The first CPT manual was pocket sized and contained only 163 pages. It contained four-digit codes, along with brief descriptions.

The CPT manual has grown in size and descriptions since 1966. The CPT manual now contains six main sections, which are divided into subsections, and then further divided into subcategories and headings. It now contains thousands of codes, which continue to be revised and updated annually.

# The Structure and Design of CPT

The CPT update notifications are released in early fall to allow time for providers to become educated and update their systems to be in compliance with the January 1 code changes. Coding changes that are announced include additions, deletions, and code revisions from the previous year. Coders need to review the annual updates in CPT so that they have an understanding of the most current codes; therefore, submitted claims will not be rejected because of invalid or outdated codes.

The CPT manual consists of an introduction, the main body of the book, the appendices, and the index. To locate a procedure completed during an encounter, the coder may need to look for the service in several different ways. Becoming familiar with the layout and format of the book will help the coder to better locate a code.

In order to become familiar with the contents of the CPT manual, you should use your CPT manual and locate the following (the table of contents for CPT is found at the front of the manual):

- Introduction
- Evaluation and Management Services Guidelines
- Evaluation and Management
- Anesthesia Guidelines
- Anesthesia
- Surgery Guidelines
- Surgery
- Radiology Guidelines (Including Nuclear Medicine and Diagnostic Ultrasound)
- Radiology
- Pathology and Laboratory Guidelines
- Pathology and Laboratory
- Medicine Guidelines
- Medicine

- Category II Codes
- Category III Codes
- Appendices
- Index

## The Introduction

The introduction to the CPT manual contains valuable information that will help you navigate through the manual. Text, symbols, history, and how to use the book are all explained within the introduction section of the manual.

Also found in the introduction is a breakdown of the section numbers and their sequence, instructions for using the CPT manual and for formatting, and an explanation of guidelines, add-on codes, and modifiers. To become familiar with the information found within the introduction, read the introduction contained within the CPT manual.

## Symbols

Various symbols are used to alert the coder to unique features of the CPT manual. Symbols that are included in the CPT manual are discussed below. The symbols are located in front of the code numbers within the various sections to denote that the symbol applies to a specific code.

### Triangle Symbol ▲

The **triangle symbol** is used to denote that a code has been revised from the previous edition of CPT with a substantial change in the CPT description of the procedure or service. Appendix B contains a summary of codes that have been revised, as well as additional and deleted codes. When a code is revised, the triangle symbol will appear before the code number in the main body of the CPT manual. In Appendix B, the triangle symbol will appear before the code number, and the deleted language in the code description will be noted with a strikethrough. The newly added information will be underlined.

In the 2021 edition of CPT, for example, code number 19328 was revised.

**EXAMPLE:** In 2020, the code descriptor stated:

```
19328   Removal of intact mammary implant
```

In 2021, the code descriptor was revised as follows:

```
19328   Removal of intact breast implant
```

Reference code 19328 in the CPT manual and in Appendix B to note how this symbol is used.

### Bullet Symbol ●

The **bullet symbol** is used to denote a new code that has been added since the previous edition of CPT. In the body of the CPT manual, the bullet symbol will appear before the code number. A summary of these newly added codes appears in Appendix B of the CPT manual. In Appendix B, the bullet symbol appears next to the new code number with the phrase “Code added.” The full description of the new code does not appear in Appendix B.

In the 2021 edition of CPT, the following appeared as a new code:

**EXAMPLE:** 32408 Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed.

Review this code addition in both Appendix B and in the CPT manual Surgery code section and note how the bullet symbol is used.

## Horizontal Triangles Symbol ►◄

The **horizontal triangles symbol** is used to indicate new or revised text in the CPT manual. When the horizontal triangle symbol appears, the coder must note the information that has been added or revised from the previous edition of the CPT manual.

**EXAMPLE:** In the 2021 edition of CPT, revised text appears before code 33300. Reference this section in the CPT manual to review the revised information, and note the location of the horizontal triangles that appear around the paragraph that starts with "Patients receiving major cardiac procedure may require .....".

## Add-on Code Symbol +

The **add-on code symbol** is used within CPT to list procedures that are completed in addition to the primary procedure or service performed. Appendix D in the CPT manual lists these codes, and they are denoted in the body of the CPT manual when the add-on code symbol appears before the code number. Add-on codes must be reported in addition to the primary procedure or service code and can never be reported alone. In addition, they are to be reported by the same provider of the service. Additional information on add-on codes is located in the Introduction of the CPT manual under the heading of "Add-on Codes."

**EXAMPLE:** 11000 Debridement of extensive eczematous or infected skin; up to 10% of body surface +11001 each additional 10% of the body surface, or part thereof (List separately in addition to code for primary procedure)

The placement of the symbol alerts the coder that code 11001 is an add-on code and can be used only in conjunction with code 11000.

## Number Symbol #

The **number symbol** indicates codes that are out of numerical sequence. As CPT codes have been added over the years, codes have been listed out of numerical order to allow the placement of procedures with related concepts within code families, regardless of the availability of sequential numerical code numbers. The number symbol is used in the body of the CPT manual to indicate a code that is out of numerical order. The symbol will precede other symbols that have been assigned to a code.

**EXAMPLE:**

Excision

```
          (For bone biopsy, see 20220-20251)
   21550  Biopsy, soft tissue of neck or thorax
          (For needle biopsy of soft tissue, use 20206)
   21552  Code is out of numerical sequence. See 21550-21558
   21554  Code is out of numerical sequence. See 21550-21558
   21555  Excision, tumor, soft tissue of neck or anterior thorax,
          subcutaneous; less than 3 cm
 # 21552  3 cm or greater
```

Code 21552 is the code that is out of numerical sequence. Appendix N lists a summary of resequenced CPT codes, thus indicating the codes that do not appear in the body of the CPT manual in numerical order.

## Forbidden or Prohibitory Symbol ⃠

The **forbidden or prohibitory symbol** indicates that a code is exempt from modifier –51 and also has not been denoted as a CPT add-on code. Modifier –51 indicates that multiple procedures have been performed. The use of modifiers will be discussed later in the textbook. Appendix E of the CPT manual lists the summary of CPT codes that are exempt from modifier –51. Review Appendix E for the complete list of codes that are exempt from the use of modifier –51.

⃠ **20974** Electrical stimulation to aid bone healing; noninvasive (nonoperative)

## Hollow Circle Symbol ∘

The **hollow circle symbol** indicates a reinstated or recycled code in CPT. This symbol is used in the CPT manual only if a code has been reinstated. In those years in which no codes are reinstated or recycled, the hollow circle symbol will not appear in the code book.

In 2010, code 1127F was deleted, and then it was reinstated in 2012. Thus, the following example appeared in the 2012 edition of CPT:

**EXAMPLE:**

**∘1127F** New episode for condition (NMA—No Measure Associated)

This symbol only appears the year it has been reinstated, therefore, the 2021 edition of CPT does not have the hollow circle symbol next to this code.

## Flash Symbol ↯

The **flash symbol** indicates codes for vaccines that are pending FDA approval. To see examples of vaccines awaiting FDA approval, reference Appendix K in the CPT manual.

## Proprietary Laboratory Analyses (PLA) Tests Symbol ⌘

The **proprietary laboratory analyses (PLA) tests symbol**, ⌘, is used to denote duplicate proprietary laboratory analyses (PLA) tests. The PLA codes define proprietary clinical laboratory analyses. Appendix O, of the CPT manual, includes all codes that are included in the Proprietary Laboratory Analyses subsection of the Pathology and Laboratory Section of the CPT manual. PLA test codes will be further defined in the Pathology and Laboratory chapter of this textbook. **The Category I proprietary laboratory analyses (PLA) tests symbol** ⇅ is used to identify Category I PLA codes. For a full explanation of PLA codes and the use of symbols that relate to PLA reference the information found in the CPT manual prior to code 0001U found at the end of the Pathology and Laboratory section of the coding manual.

## Star Symbol ★

The **star symbol** was added in the 2017 edition of CPT to denote codes that may be used to report synchronous (real-time) telemedicine services when modifier –95 is appended to the code. Telemedicine services are services that are rendered using electronic communication and encompasses interactive telecommunications, which, at a minimum, includes video and audio communication between the patient and the provider. The star symbol is listed in the CPT manual preceding the code number. Appendix P of the CPT manual lists the CPT codes that can be used as telemedicine codes. In 2020 as the United States faced the COVID-19 pandemic the country saw an increase in telemedicine services. Telemedicine is a safe manner in which patients could "see" their providers without having to leave their homes and face the possibility of being exposed to COVID-19.

**EXAMPLE:** Dr. Jones treats patients with a diagnosis of Parkinson's Disease who reside in a nursing home facility via telemedicine services to evaluate the progression of the disease. Dr. Jones selects the evaluation and management code 99309 to report the subsequent nursing facility care services. Code 99309-95 is used to report this service since this is performed via telemedicine.

Reference code 99309 in the evaluation and management section of the CPT manual and note that the star symbol appears before the code to indicate that this service can be provided via telemedicine. Further explanation of the use of modifier –95 will be explained in Chapter 2 of this textbook.

## Sections, Subsections, Categories, Subcategories, and Headings of the CPT Manual

There are six main sections in CPT. These main sections are as follows. (Note that the sections do not appear in numerical order within the CPT manual.)

| Section Title | Code Range |
|---|---|
| Evaluation and Management | 99202–99499 |
| Anesthesia | 00100–01999, 99100–99140 |
| Surgery | 10004–69990 |
| Radiology | 70010–79999 |
| Pathology and Laboratory | 80047–89398, 0001U–0222U |
| Medicine | 90281–99199, 99500–99607 |

Each main section is divided further into subsections arranged by anatomic site, procedure, descriptors, or condition subheadings.

**EXAMPLE:** Referencing the Surgery section of the CPT manual you will see the following arrangement for codes that relate to incision and drainage procedures of the integumentary system. I have selected the specific code 10080 for this illustration:

```
(Section) Surgery
  (Subsection) Integumentary System
     (Subcategory) Skin, Subcutaneous, and Accessory Structures
       (Heading) Incision and Drainage
         (Procedure) 10080 Incision and drainage of pilonidal cyst; simple
```

The coder should keep in mind that the CPT manual is also arranged from head to toe and from the trunk outward. The Surgery section illustrates this clearly with the procedures for the Musculoskeletal System.

**EXAMPLE:**

```
(Section) Surgery
  (Subsection) Musculoskeletal System
     (Subcategory) Head
       (Heading) Incision
         (Procedure) 21010 Arthrotomy, temporomandibular joint
```

The next subcategory is the Neck (Soft Tissues) and Thorax, with the heading of "Incision," starting with procedure code 21501. Then the code subcategories move on to the Back and Flank, Spine (Vertebral Column), Abdomen, Shoulder, Humerus (Upper Arm) and Elbow, Forearm and Wrist, and Hand and Fingers. The subcategories continue in the same manner, beginning with the Pelvis and Hip Joint and moving the rest of the way down the body.

The codes are in numeric order within each section of the code manual, except for those cases when codes have been added out of sequence. These out-of-sequence codes are identified by the number symbol (#), as discussed earlier in this chapter. Locating specific codes will be discussed later in this chapter.

When a code is located in the main section of the CPT manual, please be aware of semicolon (;) use within the code descriptions. The semicolon is a very important symbol in CPT; it is the key to making proper code selections. The semicolon separates the common portion of the procedure description from the unique portion of the procedure description.

**EXAMPLE:** The provider documentation states, "I&D of a pilonidal cyst was performed today. Extensive amounts of pus were exudated. Patient tolerated procedure well. This is considered a complicated I&D because of the presence of infection."

The procedure codes for this case are found in the Surgery section and read as follows:

```
10080   Incision and drainage of pilonidal cyst; simple
10081      complicated
```

The code 10081 would be selected to report this procedure.

The way to read the code description for code 10081 properly is, "Incision and drainage of pilonidal cyst; complicated." The indentation indicates that after the semicolon, the term "complicated" is used for code 10081.

## Exercise 1.1—Check Your Understanding

**For the codes given, indicate the section and subsection where the code is found. The first one is done for you.**

| Code | Section/Subsection | Code | Section/Subsection |
|---|---|---|---|
| 1. 70300 | Radiology/Diagnostic Radiology (Diagnostic Imaging) | 10. 65112 | _____ |
| 2. 60220 | _____ | 11. 90371 | _____ |
| 3. 26034 | _____ | 12. 99203 | _____ |
| 4. 88036 | _____ | 13. 10160 | _____ |
| 5. 43651 | _____ | 14. 33120 | _____ |
| 6. 38115 | _____ | 15. 50100 | _____ |
| 7. 99304 | _____ | 16. 21811 | _____ |
| 8. 97010 | _____ | 17. 66184 | _____ |
| 9. 77021 | _____ | 18. 52441 | _____ |
| | | 19. 61000 | _____ |
| | | 20. 59074 | _____ |

## Guidelines

At the start of each of the CPT main sections, section-specific guidelines are presented. **Guidelines** define items that are necessary for appropriately interpreting and reporting the procedures and services contained within that section of the CPT manual. The guidelines specific to each section of CPT codes are strictly followed. Guidelines are provided at the start of each main section, but guidelines, or notes, may also appear at the beginning of a subsection.

**EXAMPLE:** In the Surgery section, prior to the description for code 11200, the following note appears after the heading "Removal of Skin Tags":

Removal by scissoring or any sharp method, ligature strangulation, electrosurgical destruction, or combination of treatment modalities, including chemical destruction or electrocauterization of wound, with or without local anesthesia.

This note further explains that if the skin tag was removed by any method listed, it would be proper to assign the appropriate CPT code from this subsection.

Coders should read and review each of the guideline sections at the start of each year for any noted changes that may have been made from the prior year's guidelines. As discussed earlier in this chapter, when text changes are made the revised text will appear within the horizontal triangles symbol.

## Index

The Index is located in the back of the CPT manual. Instructions for the use of the CPT Index appear in the back of the CPT manual prior to the Index. The Index is organized by main terms. The main terms, which are in bold print, are organized by one of the following:

1. Procedure or Service
2. Organ or other Anatomic Site
3. Condition
4. Synonyms, Eponyms, and Abbreviations

When locating a term in the index, always follow this order. First, attempt to locate the main term by the name of the procedure or service, then attempt to identify it by organ or anatomic site, then by condition, and last by synonyms, eponyms, or abbreviations.

Main terms in the Index can be followed by a series of subterms that modify the main term. Subterms further define or clarify the main term. The coder must review the subterms because they have an effect on the selection of the appropriate code for the procedure. Some entries in the Index will have more than one code that applies to a given index entry; a range of codes will be listed. You will notice a comma separating the two codes. If more than two codes in a series apply, they will be separated by a hyphen. The coder must reference all the codes listed in the Index in the main section of the CPT manual. The coder should select the code after referencing the main sections. Always verify codes in the main text of CPT.

## Appendices

The appendices are located in the back of the CPT manual, before the Index. Locate the appendices in the CPT manual and review the content found in each appendix of the manual. The appendices in CPT can be summarized as follows.

| Appendix | Description |
|---|---|
| Appendix A—Modifiers | Detailed description of each of the modifiers used with CPT codes. |
| Appendix B—Summary of Additions, Deletions, and Revisions | Additions, deletions, and revised CPT codes for the current edition of CPT. This is a good reference at the beginning of the year when a new edition of CPT is published as it can be referenced for updating billing sheets and code summary sheets used by clinical staff. The appendix shows the actual changes that have been made to the code descriptions, new codes that have been added and deleted codes. In Appendix B of the CPT manual, read through the paragraph following the heading for additional information about how the symbols are used in this appendix. |
| Appendix C—Clinical Examples | Clinical examples for codes found in the Evaluation and Management section of CPT. This appendix provides valuable information about the selection of Evaluation and Management, E/M, codes and provides clinical examples of cases for various E/M codes. |
| Appendix D—Summary of CPT Add-on Codes | List of add-on codes found throughout CPT. Add-on codes can be recognized within the sections of the CPT manual because preceding the code number the + symbol is listed in the CPT manual. |

(*continues*)

(*continued*)

| Appendix | Description |
|---|---|
| Appendix E—Summary of CPT Codes Exempt from Modifier 51 | The codes listed here are exempt from use of a −51 modifier. |
| Appendix F—Summary of CPT Codes Exempt from Modifier 63 | The codes listed here are exempt from use of a −63 modifier. |
| Appendix G—Summary of CPT Codes That Include Moderate (Conscious) Sedation | On January 1, 2017, the summary of CPT codes that include moderate (conscious) sedation, Appendix G, was removed from the CPT appendices. Appendix G now states that for information and guidance on reporting moderate sedation services the coder should reference the guidelines for codes 99151, 99152, 99153, 99155, 99156, and 99157. |
| Appendix H—Alphabetical Clinical Topics Listing (AKA, Alphabetical Listing) | This appendix, which included the Alphabetical Clinical Topics Listing, has been removed from the CPT manual. The appendix now lists the AMA website for obtaining this information. |
| Appendix I—Genetic Testing Code Modifiers | Genetic testing code modifiers have been removed from the CPT manual. The appendix now lists a website to reference for up-to-date information. |
| Appendix J—Electrodiagnostic Medicine Listing of Sensory, Motor, and Mixed Nerves | This appendix contains a listing of sensory, motor, and mixed nerves and the appropriate nerve conduction study code that is used. This should be referenced when selecting codes 95907–95913. |
| Appendix K—Product Pending FDA Approval | This appendix contains a listing of vaccines pending FDA approval. |
| Appendix L—Vascular Families | Appendix L contains a listing of vascular families, the branch order, and those families commonly reported during arteriographic procedures. |
| Appendix M—Renumbered CPT Codes–Citations Crosswalk | This appendix contains a listing of renumbered and crosswalked codes and their descriptions. |
| Appendix N—Summary of Resequenced CPT Codes | Appendix N contains a listing of the CPT codes that are not in numerical order in the CPT manual. This appendix can be referenced to identify the codes out of numerical order. |
| Appendix O—Multianalyte Assays with Algorithmic Analyses and Proprietary Laboratory Analyses | This appendix lists codes that are unique to a single clinical laboratory or manufacturer. |
| Appendix P—CPT Codes That May Be Used for Synchronous Telemedicine Services | This appendix is a summary of the CPT codes that may be used to report real-time telemedicine services. |

Become familiar with the contents of the appendices because they provide an excellent source for reference information.

# CPT as Part of HCPCS

Until 1983, CPT codes were recognized only by private insurance companies. After that time, the Healthcare Financing Administration developed the **Healthcare Common Procedure Coding System (HCPCS)**, using CPT codes as part of the HCPCS system for reporting Medicare services. The Healthcare Financing Administration is now known as the Centers for Medicare and Medicaid Services (CMS). The CPT codes that were already in use became the Level I or Category I codes of the new HCPCS coding system for the Medicare program. Some third-party payers also recognize the additional codes in HCPCS.

## HCPCS

The Healthcare Common Procedure Coding System, commonly referred to as HCPCS (pronounced "hicpics"), is divided into Level I and Level II.

## HCPCS Level I

The CPT codes are **Level I codes**. These codes are divided into Category I, Category II, and Category III. **Category I** codes are the codes from the main sections of CPT:

- Evaluation and Management
- Anesthesia
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine

These codes are used to report services rendered by providers. They are mandatory.

**Category II** codes are not mandatory and are considered tracking codes. In the CPT manual, following the Medicine section, Category II codes can be located. Category II codes should never be used as a primary procedure code.

**EXAMPLE:** The following code represents a Category II code:

```
1005F   Asthma symptoms evaluated (includes documentation of numeric
        frequency of symptoms or patient completion of an asthma
        assessment tool/survey/questionnaire) (NMA-No Measure Associated)
```

**Category III** codes, located in the CPT codebook after the Category II codes, are temporary codes for emerging technologies, services, procedures, and service paradigms, and are used for the collection of statistical data. With the creation of new procedures and technologies, these temporary codes can be assigned as additional codes to track their use. To become familiar with the reporting guidelines for Category III codes, reference the Category III code listing in the CPT manual. (The Category Code listing is found in the section prior to the start of the Appendices in the CPT manual.) As stated in this section of the CPT manual, if a Category III code is available, the Category III code must be reported instead of a Category I unlisted code. This will be discussed further later in the textbook.

**EXAMPLE:** The following represents a Category III code:

```
0208T   Pure tome audiometry (threshold), automated; air only
```

## HCPCS Level II

HCPCS **Level II codes** are commonly referred to as **National Codes**. These codes are published annually by the Medicare program and are used to bill for services and procedures that are not included in the Level I codes. These codes can be obtained on the Centers for Medicare and Medicaid Services (CMS) website and from the published annual edition of the codes. HCPCS Level II codes consist of one alpha character (A through V) followed by four digits. HCPCS Level II codes are discussed in Chapter 23 of this textbook.

# Summary

- Current Procedural Terminology (CPT) comprises codes and guidelines used by the medical profession to report procedures and services provided to a patient during an encounter.
- The introduction of CPT contains explanations of the symbols used, how to maneuver through the book, and instructions for using the book.
- The main sections of CPT contain the codes used to report procedures to the insurance company/payer.

- The index helps the coder find the service that needs to be reported.
- The appendices further assist the coder with quick references to modifiers and coding changes.

# Internet Links

For more information about CMS and the HCPCS coding system, visit ***http://www.cms.gov***.

# Chapter Review

## True/False

**Instructions:** Indicate whether the following statements are true (T) or false (F).

1. _____ CPT codes tell the insurance carrier what brought the patient to the physician's office.
2. _____ Text, symbols, and the history of CPT are found in the introduction of the code book.
3. _____ The CPT code book is updated annually on July 1.
4. _____ The Surgery section of codes begins with code 10001 and goes through code 69999.
5. _____ ▲ is the symbol for a revised code.

## Fill in the Blank

**Instructions:** Fill in the blanks in the statements that follow.

6. The CPT coding system was first published in 1966 by _____.
7. A complete and detailed description of all modifiers used in CPT is found in _____.
8. The CPT manual contains _____ main sections.
9. The _____ separates the common portion of the code description from additional portions of the code.
10. The _____ is organized by main terms.

# Coding Assignments

For each code listed, note the main section of the CPT manual in which you would find the code. The first one is done for you.

1. 00142 Anesthesia
2. 23076 _____
3. 88348 _____
4. 62281 _____
5. 65091 _____
6. 90935 _____
7. 99456 _____
8. 75810 _____
9. 37766 _____
10. 93283 _____
11. 64400 _____
12. 77003 _____
13. 30520 _____
14. 89264 _____

**15.** 92326 _____

**16.** 90651 _____

**17.** 80345 _____

**18.** 77307 _____

**19.** 33955 _____

**20.** 99188 _____

## Short Answer

Using the introduction to the CPT manual as a reference, define the following.

**1.** Unlisted procedure or service

_____

_____

_____

**2.** Add-on codes

_____

_____

_____

**3.** Modifiers

_____

_____

_____

**4.** Special Report

_____

_____

_____

**5.** Alphabetical Reference Index

_____

_____

_____

**6.** Section Numbers and Their Sequences

_____

_____

_____

**7.** Using Appendix D of the CPT manual, review the following codes to determine if the code listed is an add-on code.

Next to the code, write "Yes" if the code is an add-on code or "No" if the code is not an add-on code.

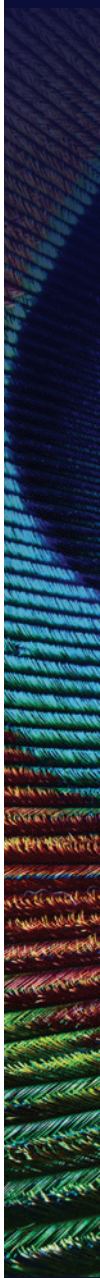
| Code | Is this an add-on code? | Code | Is this an add-on code? |
|---|---|---|---|
| 11047 | _____ | 63082 | _____ |
| 60540 | _____ | 81416 | _____ |
| 36100 | _____ | | |

**8.** Using Appendix E of the CPT manual, review the following codes to determine if the code listed is exempt from modifier –51 use.

Next to the code, write "Yes" if the code is exempt or "No" if the code is not exempt.

| Code | Is this code exempt from the use of modifier –51? | Code | Is this code exempt from the use of modifier –51? |
|---|---|---|---|
| 99202 | _____ | 93618 | _____ |
| 20975 | _____ | 36620 | _____ |
| 97535 | _____ | | |

**9.** Differentiate between Level I and Level II codes in HCPCS.



CHAPTER 2

# Modifiers

## Chapter Outline



## Learning Objectives

### At the conclusion of this chapter, you should be able to:

1. Identify where a list of CPT modifiers can be found in the CPT manual.
2. Sequence pricing and statistical modifiers in the proper order.
3. Differentiate between pricing and statistical modifiers.
4. Define the various CPT modifiers used.
5. Identify modifiers approved for hospital outpatient services.
6. Define the various HCPCS Level II modifiers used.
7. Assign CPT and HCPCS Level II modifiers to procedural statements.
8. Identify where modifiers are listed on the CMS-1500 form.

## Key Terms

alternative laboratory platform testing—modifier 92

anesthesia by surgeon—modifier 47

assistant surgeon—modifier 80

assistant surgeon (when qualified resident surgeon is not available)—modifier 82

bilateral procedure—modifier 50

CPT modifier

decision for surgery—modifier 57

discontinued outpatient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia—modifier 74

discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia—modifier 73

discontinued procedure—modifier 53

# Introduction

At times, a CPT code needs to be reported with the addition of a modifier. Modifiers give additional information, when necessary, about the CPT code to a third-party payer to ensure that claims are paid correctly.

# Definition and Purposes of Modifiers

A **CPT modifier** is a two-digit code that is appended to the CPT code to indicate that a service or procedure has been altered for some reason, but it does not change the main definition of the code. The modifier further describes the service performed. Two types of modifiers are used with CPT codes: **Level I (CPT) modifiers** are two-digit numeric codes, whereas **Level II (HCPCS/National) modifiers** are two-digit alphanumeric modifiers. A complete listing of Level I modifiers is contained in Appendix A of the CPT manual. To become familiar with the modifier codes and descriptions, review Appendix A of the CPT manual.

Modifiers are used for various reasons, including the following:

- A service or procedure has both a technical and professional component.
- A service or procedure was performed by more than one physician.
- A service or procedure was performed in more than one location.

- A service or procedure has taken more time to complete than routinely would occur.
- A service or procedure was reduced or increased.
- Only part of a procedure was completed.
- A bilateral procedure was performed.
- A service or procedure was completed multiple times.
- An unusual event occurred during the procedure.
- An accompanying or adjunctive procedure was performed.

# Use of Modifiers for Various Procedures and Service Locations

As mentioned earlier in this chapter, Appendix A of the CPT manual lists the Level I modifiers. It should be noted that instruction is also given as to which modifiers are used for physician services and which modifiers are appropriate for ambulatory surgery center hospital outpatient use.

## Modifiers Used with Physician Services

When billing physician services, place modifiers in item 24d of the CMS-1500 form, following the CPT code. Appendix I of this textbook provides an example of the CMS-1500 form. Reference Appendix I, Figure A1-1, of this textbook to see where to place the modifier on the CMS-1500 form.

When reporting modifiers for Medicare claims, the CPT code is followed by the modifier. It should be noted that some third-party payers use different instructions for reporting modifiers. It is important to review the modifier instructions for the payer you are billing. This will be explained further when we discuss the various modifiers.

The CMS-1500 claim form contains modifier fields. For Medicare claims, when you enter only one modifier, enter it in the first modifier field. When more than one modifier is submitted, the modifiers must be ranked according to whether the modifier will affect the fee for the service. Modifiers that affect pricing are listed in Table 2-1 and should be reported in the first modifier field because they directly affect the fee for a service. The modifiers listed in Table 2-1 are often referred to as **pricing modifiers**, and they either increase or decrease the fee for the service.

The remaining modifiers, often referred to as **statistical modifiers** or **informational modifiers**, are used for informational purposes and have an impact on the processing or payment of the code billed but do not affect the fee. Table 2-2 lists the statistical/informational modifiers.

It is important for the coder to also enter the pricing modifier in the first modifier field.

**EXAMPLE:** Ranking of Two Modifiers—One pricing modifier and one statistical modifier.

Assume that Dr. Smith performed an open incision and drainage of an appendiceal abscess and reported code 44900. Two days later, Dr. Smith repeated the same procedure on the same patient. During this episode of care, he only performed the surgical care; therefore, modifier 54, surgical care only, would be appended to the code 44900. Because this is a repeat procedure by the same physician, modifier 76 also would have to be reported. Therefore, modifier 54 should be reported in the first modifier field, because it affects pricing, and modifier 76 would be entered in the second modifier field, because it does not affect pricing.

**TABLE 2-1** Pricing Modifiers That Affect Fees

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AA | AD | AH | AJ | AS | GM | QB | QK | QU | QX | QY | QZ |
| SG | TC | UN | UP | UQ | UR | US | 22 | 26 | 50 | 51 | 52 |
| 53 | 54 | 55 | 56 | 62 | 66 | 73 | 74 | 78 | 80 | 82 | 99 |

**TABLE 2-2** Statistical and Informational Modifiers

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AE | AF | AG | AK | AR | AT | AM | CC | CG | E1 | E2 | E3 |
| E4 | EJ | EM | EP | ET | F1 | F2 | F3 | F4 | F5 | F6 | F7 |
| F8 | F9 | FA | FP | G1 | G2 | G3 | G4 | G5 | G6 | G7 | G8 |
| G9 | GA | GB | GC | GE | GG | GH | GJ | GN | GO | GP | GQ |
| GT | GV | GW | GY | GZ | KO | KP | KQ | KX | LC | LD | LR |
| LS | LT | Q3 | Q4 | Q5 | Q6 | Q7 | Q8 | Q9 | QA | QC | QD |
| QL | QM | QN | QP | QQ | QS | QT | QV | QW | RC | RD | RP |
| RT | SF | SW | SY | T1 | T2 | T3 | T4 | T5 | T6 | T7 | T8 |
| T9 | TA | VP | 23 | 24 | 25 | 32 | 47 | 57 | 58 | 59 | 76 |
| 77 | 79 | 90 | 91 | 95 | | | | | | | |

When reporting more than one statistical or informational modifier with no other pricing modifiers, you can report the statistical or information modifiers in any order, with the exception of the QT, QW, and SF modifiers. These three modifiers are valid for use only in the first modifier field. Assume that modifiers T7 and 58 are being reported together. The modifiers can be sequenced in any order because they are both statistical modifiers.

## Exercise 2.1—Check Your Understanding

**List the modifiers given in the series in the proper order. If the order does not make a difference, indicate this with ND.**

1. 62, 22 _____
2. GW, US _____
3. 56, QT _____
4. AA, 47 _____
5. 59, 51 _____

## Use of Multiple Modifiers—Modifier 99

**Modifier 99—multiple modifiers** indicates that multiple modifiers are needed for an individual CPT code. This modifier is not recognized by all insurance plans, so coders must review the coding guidelines for plans that are being billed. Medicare recognizes modifier 99, and coders should refer to Medicare administrative contractor information for instructions on reporting this modifier. Many Medicare administrative contractors require modifier 99 to be entered in the first modifier field when more than two modifiers apply. Additional information is required in the narrative field (item 19 on the claim form), listing all modifiers in the correct ranking order.

## Exercise 2.2—Check Your Understanding

**Pricing and Statistical/Informational Modifiers**

For the following modifiers, state whether the modifier is a pricing modifier or a statistical/informational modifier.

| Modifier | Type | Modifier | Type |
|---|---|---|---|
| 1. 52 | _____ | 6. 23 | _____ |
| 2. E3 | _____ | 7. 59 | _____ |
| 3. 82 | _____ | 8. 50 | _____ |
| 4. 78 | _____ | 9. 77 | _____ |
| 5. GN | _____ | 10. QD | _____ |

# Modifiers Used for Hospital Outpatient Services

Hospital outpatient services are reported on the UB-04 form, also known as the CMS-1450 form. When modifiers are reported for these services, they should be placed in field 44 of that form. Reference Appendix I, Figure A1-2, of this textbook to determine where modifiers should be placed on a UB-04/CMS-1450 form.

## Modifiers Approved for Ambulatory Surgery Center Hospital Outpatient Use

Not all modifiers are approved for use on ambulatory surgery claims. The list of approved modifiers is reviewed annually. Table 2-3 lists the currently approved modifiers. Appendix A of the CPT manual also lists the modifiers that are approved for the ambulatory surgery setting. Familiarize yourself with the modifiers used in this setting by reading the listing and the modifiers' descriptions in Appendix A of the CPT manual.

**TABLE 2-3** Modifiers Approved for Ambulatory Surgery Center Hospital Outpatient Use

| *Level I Modifiers* | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 25 | 27 | 33 | 50 | 52 | 58 | 59 | 73 | 74 | 76 | 77 | 78 | 79 | 91 |
| *Level II Modifiers* | | | | | | | | | | | | | |
| LT | RT | E1 | E2 | E3 | E4 | FA | F1 | F2 | F3 | F4 | F5 | F6 | |
| F7 | F8 | F9 | TA | T1 | T2 | T3 | T4 | T5 | T6 | T7 | T8 | T9 | |
| LC | LD | LM | RC | RI | GG | GH | QM | QN | XE | XS | XP | XU | |

## Exercise 2.3—Check Your Understanding

**Modifiers Used for Ambulatory Surgery Center Hospital Outpatient Claims**

Mary Smith is an outpatient surgery coder at Sunny Valley Hospital, and she is developing a list of modifiers that can be used in this setting. Next to the modifier listed, write "Yes" if the modifier should be used in this setting or "No" if the modifier should not be used in this setting.

| Modifier | Use in Outpatient Surgery Setting? | Modifier | Use in Outpatient Surgery Setting? |
|---|---|---|---|
| 1. 22 | _____ | 9. E4 | _____ |
| 2. 50 | _____ | 10. RT | _____ |
| 3. 53 | _____ | 11. F3 | _____ |
| 4. 59 | _____ | 12. TC | _____ |
| 5. 62 | _____ | 13. RC | _____ |
| 6. 66 | _____ | 14. GG | _____ |
| 7. 73 | _____ | 15. T1 | _____ |
| 8. 76 | _____ | | |

# CPT Level I Modifiers

The best way to understand how to use modifiers is to review the definition for each modifier found in Appendix A of the CPT manual. Here, we discuss the use of each modifier and give examples of cases that require modifier use. The titles of the modifiers are listed as they appear in the CPT manual.

## Increased Procedural Services—Modifier 22

Assign **modifier 22** when the service provided is greater than that usually required for the listed procedure. This modifier should not be appended to an Evaluation and Management code.

**EXAMPLE:** A radical abdominal hysterectomy with bilateral total pelvic lymphadenectomy and para-aortic lymph node biopsy was performed on Peg Smith. The procedure took 50 minutes longer than normal because, during the surgery, the patient experienced prolonged bleeding.

The code to report would be 58210-22 because of the unusual amount of time that it took to complete the procedure.

The use of modifier 22 is tracked by insurance companies. This should be used only for cases that are truly unusual and for which documentation of the case can justify the unusual aspect of the service. The surgeon needs to identify the additional work, such as technical difficulties during the procedure, or an increased intensity and/or time, just to name a few items. When this modifier is reported, an operative note will be requested and a special report may be requested, which would require the following information:

- A complete description of the procedure performed.
- The reason the service fell outside the parameters of the CPT code description.
- The time, effort, and equipment used during the procedure.
- The complexity of the case, describing the patient's condition and symptoms that occurred during the procedure.
- The preoperative and postoperative diagnoses.
- Pertinent physical findings that influenced the case and procedure.
- Any diagnostic and therapeutic services that were rendered in association with the procedure.
- Concurrent diagnosis, symptoms, and problems that were present.
- The anticipated follow-up care.

## Unusual Anesthesia—Modifier 23

Occasionally, a procedure that routinely is not completed with any type of anesthesia or local anesthesia requires the use of general anesthesia. When this occurs, **modifier 23** is appended to the CPT code.

**EXAMPLE:** Randy Hill is a patient with a psychiatric condition who needs to undergo surgery for a simple drainage of a finger abscess. Because the patient has much anxiety about the procedure, the physician uses general anesthesia on him.

The code to report is 26010-23.

## Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During Postoperative Period—Modifier 24

For each procedure, a postoperative period is established that denotes the usual postoperative period for the condition related to the surgery. When a patient is seen for an **unrelated Evaluation and Management service during a postoperative period**, **modifier 24** is appended to the Evaluation and Management code, abbreviated

E/M code. This would indicate that an E/M service was performed during a postoperative period for a reason or reasons unrelated to the original procedure. The diagnosis code reported for the unrelated Evaluation and Management service must reflect the reason for the unrelated service.

**EXAMPLE:** Sally Monk had an open cholecystectomy. Five days after the surgery, she experienced chest pain and was seen by the same physician who performed the surgery. He evaluated the chest pain.

The physician reported code 99213-24 to indicate that she was seen for a condition unrelated to the surgery. The diagnosis code for this visit would be chest pain, which is a condition that is not related to the cholecystectomy.

## 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—Modifier 25

**Modifier 25** is added to any appropriate level of an Evaluation and Management service when the physician needs to indicate that on the day a procedure or service was performed, the patient's condition required a significant, separately identifiable Evaluation and Management service that was above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

**EXAMPLE:** Devon presented to the doctor's office with knee pain that was a result of a sports injury. The physician examined Devon and determined that he had tendonitis. In the course of his examination, several warts were noted on the plantar side of Devon's left foot. The doctor felt that treatment should be started due to the size of two of the three warts. Devon did state that he has pain when wearing his shoe gear.

The physician reported code 99213-25 with a diagnosis of knee pain and tendonitis; in addition, he reported 17110 for cryotherapy treatment of the warts. The diagnosis code assigned to 17110 would be plantar warts. As per the definition of modifier 25, there are times when the Evaluation and Management service may be prompted by the same symptom or condition for which the procedure and/or service was provided; therefore, in these cases, different diagnoses are not required for the reporting of the E/M service on the same date.

## Professional Component—Modifier 26

A number of CPT procedures have both a professional and a technical component. Examples of codes that have both a professional and a technical component include codes in the Pathology and Radiology chapters and cardiology codes found in the Medicine chapter of CPT. When a physician is reporting only the professional component, the service is identified by adding **modifier 26** to the usual procedure number.

**EXAMPLE:** Dr. Ty, a radiologist, interprets a four-view x-ray examination of the cervical spine.

This is reported using code 72050-26.

Modifier 26 should not be appended to codes that represent a professional component but do *not* have a technical component as part of the code definition. An example of a code that represents only the professional component is code 93042—Rhythm ECG, one to three leads; interpretation and report only.

## Multiple Outpatient Hospital E/M Encounters on the Same Date—Modifier 27

**Modifier 27** is appended to an E/M service code when separate and distinct E/M encounters are performed in multiple outpatient hospital settings on the same date. This modifier is not to be used for physician reporting of

multiple E/M services performed by the same physician on the same day. This is to be used for the reporting of services in the Hospital Outpatient Prospective Payment System.

**EXAMPLE:** Jack Jones is seen by Dr. Smith in the podiatry clinic at Sunny Valley Hospital, and Dr. Smith selects code 99213 to report the services provided. Later that day, Jack Jones goes to the oncology clinic at Sunny Valley Hospital, and Dr. Johnson selects code 99214.

Dr. Smith would report code 99213, and Dr. Johnson would report code 99214-27.

## Mandated Services—Modifier 32

At times, services are performed because the service is required or mandated by an insurance company or by a governmental, legislative, or regulatory agency. When this occurs, **modifier 32** is appended to the CPT code to indicate that the service was a mandated service.

**EXAMPLE:** Joe Wenn was in an automobile accident. His auto insurance company is mandating that he be examined by Dr. Spy to determine the extent of his injuries. Joe has already been seen by his own primary care physician. Because Dr. Spy's examination of Joe is mandated by the auto insurance company, modifier 32 should be appended to the E/M code that Dr. Spy submits.

Dr. Spy submits code 99214-32.

## Preventive Service—Modifier 33

**Modifier 33** is used for the purpose of identifying the delivery of an evidence-based service in accordance with a U.S. Preventive Services Task Force A or B rating. The modifier is appended to codes representing preventive services. For separately reported services specifically identified as preventive, the modifier should not be used.

## Anesthesia by Surgeon—Modifier 47

**Modifier 47** is used by physicians or surgeons only when regional or general anesthesia is provided by the same physician or surgeon who is completing a procedure or service. This modifier is not to be used when local anesthesia is used. This modifier is appended to a procedure code or service code and is never appended to the anesthesia code.

**EXAMPLE:** Dr. Smith performs a dilation of the esophagus by unguided bougie under general anesthesia on patient Bobby Jones.

Dr. Smith reports 43450-47.

## Bilateral Procedure—Modifier 50

**Modifier 50** is used by both facilities and professionals when bilateral procedures are performed in the same operative session. It is used only with codes that describe a unilateral procedure. Modifier 50 is not used on codes that describe bilateral procedures, such as code 31231—Nasal endoscopy, diagnostic, unilateral, or bilateral. It should be noted that some payers prefer RT (right) or LT (left) modifiers instead of modifier 50 and require the code to be reported twice.

**EXAMPLE:** Dr. Sinus completed a bilateral intranasal maxillary sinusotomy on Linda New.

The code to report this procedure for Medicare patients would be 31020-50. Some insurance companies instruct providers to report the codes as follows: 31020 and 31020-50 or 31020-RT and 31020-LT.

## Multiple Procedures—Modifier 51

At times, during the same operative/procedural session, multiple procedures are performed by the same provider. When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service code would be reported as listed in the CPT manual. The additional procedure(s) or service(s) would be reported by adding **modifier 51** to the additional procedure or service code(s).

**EXAMPLE:** John Jones has a puncture aspiration of an abscess on his left shoulder. During the same session, the cutting of three benign hyperkeratotic lesions also occurred.

Code 10160 would be reported for the puncture aspiration, whereas code 11056-51 would be reported for the cutting of the lesions.

This modifier is used only by providers and is not used by facilities. It should also be noted that this modifier should not be appended to designated add-on codes or Evaluation and Management codes. Appendix E within the CPT manual contains a list of codes that are exempt from modifier 51.

## Reduced Services—Modifier 52

When a service or procedure is partially reduced or eliminated at the physician's discretion, **modifier 52** should be appended to the service or procedure code. This modifier should be used to report reduced services without changing the identification of the basic service. In other words, modifier 52 is used when part of the procedure was performed, but part of the procedure or service was not completed, at the provider's discretion. The use of modifier 52 may prompt a payer to request supporting documentation. The provider documentation should clearly state the reason for the reduced service.

**EXAMPLE:** Kevin is 10 years old and is presenting for a physical for soccer camp. His physician reviews the camp forms and performs the required physical, but no comprehensive history is obtained. The examination is detailed but not comprehensive.

Kevin's physical is coded with a 99393—Periodic comprehensive preventive medicine; late childhood (age 5–11). A 52 modifier is appended because the history and examination do not meet the requirements for the comprehensive physical code that is used.

CMS states that for outpatient hospital reporting, modifiers 73 and 74 are used in place of modifier 52 for previously scheduled procedures/services that are partially reduced or canceled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia. Reference the definition of modifier 52 in Appendix A of the CPT manual for additional clarification.

## Discontinued Procedure—Modifier 53

At times, the physician may terminate a surgical or diagnostic procedure because of extenuating circumstances that threaten the well-being of the patient. **Modifier 53** would be used for cases in which the surgical or diagnostic procedure was started but discontinued. However, this modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

**EXAMPLE:** Dr. Rissen brought Danielle into the OR for an endoscopic resection of a renal tumor. Danielle was put out under general anesthesia, and the procedure was started. As Dr. Rissen moved the scope into place through the established nephrostomy and touched the tumor to prep for removal, Danielle's blood pressure dropped from 150/80 to 100/50. Dr. Rissen stopped the procedure immediately, and Danielle was sent to recovery. The surgery was rescheduled when Danielle's blood pressure was stabilized.

Dr. Rissen reported code 50562 with a 53 modifier. The code reflects the renal endoscopy through established nephrostomy with resection of tumor, and the 53 modifier indicates that the procedure was

discontinued by the surgeon due to the condition of the patient. The use of the 53 modifier indicates that additional services may be provided in the future.

As noted earlier for modifier 52, modifiers 73 and 74 are required for outpatient hospital ambulatory surgery center reporting in place of modifier 53. Reference the definition of modifier 53 for further clarification on the reporting for outpatient hospital/ambulatory surgery center reporting.

## Surgical Care Only—Modifier 54

For most surgeries, the preoperative care, the surgery, and the postoperative care are completed by the same provider. However, in some cases, elements of surgical care are divided among providers. When this occurs, modifiers are used to indicate which provider performed various elements of the surgical care. **Modifier 54** is used when one physician performed the surgical procedure and another provider or providers completed the preoperative and/or postoperative management.

**EXAMPLE:** Dr. Hill performed a repair of a ruptured spleen with a partial splenectomy on Mary Smith. A different provider performed the pre- and postoperative care.

Because Dr. Hill did not provide the preoperative and postoperative care, the code to report for Dr. Hill would be 38115-54.

Modifier 54 is not used for any procedures that have zero global surgical days. Documentation must show transfer of care between physicians to justify the separation of the reporting of the surgical code. The pre- and postoperative services provided by the physician other than the surgeon would be coded with an appropriate E/M code.

## Postoperative Management Only—Modifier 55

**Modifier 55** indicates that one provider performed the postoperative management and another provider performed the surgical procedure.

**EXAMPLE:** Dr. Hill performed a repair of a ruptured spleen with a partial splenectomy on Mary Smith. However, following the surgery, Dr. Cook provided the postoperative care.

Dr. Cook would report code 38115-55.

## Preoperative Management Only—Modifier 56

At times, a different provider will perform the preoperative care and evaluation, and another provider will perform the surgical procedure. When this occurs, **modifier 56** is used to report the preoperative care.

**EXAMPLE:** Prior to surgery, Dr. House evaluated and cared for Mary Smith. Then Dr. Hill performed a repair of a ruptured spleen with a partial splenectomy on Mary Smith.

Because Dr. House performed the preoperative care, the code to report this service would be 38115-56.

## Decision for Surgery—Modifier 57

**Modifier 57** is appended to an Evaluation and Management service code when, during the service, the initial decision was made to perform surgery.

**EXAMPLE:** Dr. Jones examined Mary Lou, a 27-year-old female patient, and determined that she needed to have a tonsillectomy and adenoidectomy. This was scheduled to occur in two weeks. Dr. Jones completed a comprehensive history and a comprehensive examination and documented medical decision making of high complexity. The encounter lasted 45 minutes.

Dr. Jones would report 99215-57.

The use of modifier 57 on a minor procedure performed on the same day as the decision for the procedure should be checked with the particular insurance carrier. Some insurance companies allow this; Medicare does not. Medicare prefers the use of a 25 modifier on the Evaluation and Management code for minor procedures with global days of 0 or 10. The coder should check with the payer to find out how they would like the decision for surgery reported.

## Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period—Modifier 58

**Modifier 58** is used during the postoperative period of a procedure when

- During the original procedure, a second procedure is planned as part of the care. (This is known as a **staged procedure**.)
- During the postoperative period, more extensive care is needed than what was rendered in the original procedure.
- During the postoperative period, therapy is required following the surgical procedure.

**EXAMPLE:** A patient presents for insertion of Heyman capsules for clinical brachytherapy. The documentation states that this is the first of two procedures.

The code for the first treatment would be 58346, and the second time the patient presents would be recorded as 58346-58.

Although this modifier indicates that more extensive care was needed, it is not to be used to report the treatment of a problem that requires a return to the operating room. In these situations, modifier 78 is appropriate.

## Distinct Procedural Service—Modifier 59

Under certain circumstances, the physician may need to indicate that a procedure or service was independent from other non-E/M services performed on the same day. **Modifier 59** identifies procedures that are not typically reported together but are appropriate under the circumstances. Different anatomical sites or procedures that are not ordinarily encountered or performed on the same day by the same physician may require use of this modifier. It should be noted that when another, already established modifier is appropriate, it should be used rather than modifier 59.

**EXAMPLE:** Six-year-old Elizabeth fell down in her driveway. She had a 3-cm laceration on her right arm and gravel embedded in the forearm of her left arm. There was an intermediate repair of the laceration on her right arm. There was a 10-square cm debridement of subcutaneous tissue, epidermis, and dermis of her left arm.

The intermediate repair of the laceration includes the debridement of the gravel and would be reported using code 12032. The debridement of the gravel that was embedded in the left arm would be coded 11042 with a 59 modifier. It should be noted that modifier 59 is not appended to an E/M service.

Effective January 1, 2015, four new HCPCS modifiers (XE, XP, XS, XU) were implemented to define specific subsets of modifier 59. The modifiers are collectively referred to as the –X {EPSU} modifiers. Please note that modifier 59 will continue to be used after January 1, 2015 with the new –X {EPSU} modifiers. Modifier 59 is one of the most widely used modifiers, and CMS felt that it was necessary to have more specific information from providers and facilities regarding the submission of the modifier, thus they established the –X {EPSU} modifiers to provide that information.

The –X {EPSU} modifiers are defined as follows:

- XE Separate Encounter—A service that is distinct because it occurred during a separate encounter.
- XS Separate Structure—A service that is distinct because it was performed on a separate organ/structure.

- XP Separate Practitioner—A service that is distinct because it was performed by a different practitioner.
- XU Unusual Non-Overlapping Service—The use of a service that is distinct because it does not overlap usual components of the main service.

CMS will continue to recognize the –59 modifier, but note that Current Procedural Terminology instructions indicate that modifier 59 should not be used when a more descriptive modifier is available. Therefore if an –X {EPSU} modifier is used for a code, it is incorrect to include modifier 59 as an additional modifier for the code.

## Two Surgeons—Modifier 62

**Modifier 62** is used when two primary surgeons work together to perform a distinct part(s) of a single reportable procedure. In this situation, each surgeon should report his or her own distinct operative work by adding modifier 62 to the single definitive procedure code. In addition, each surgeon should report any associated add-on codes for the procedure, as long as the two surgeons continued to work as primary surgeons, and append the add-on procedure codes with modifier 62.

**EXAMPLE:** Mr. Pearl needed surgery to insert a pacemaker. Dr. Johnson made the incision and created the generator pocket. At this point in the procedure, Dr. Hyder inserted the atrial electrode and programmed the pacemaker. The electrode was tested, and then Dr. Johnson closed the incision.

Both surgeons in our example would document their piece of the surgery and report the surgery using 33206-62. It should also be noted that if additional procedure(s) (including add-on procedure[s]) were performed during the same surgical session and one of the surgeons acts as an assistant, those services are reported with modifier 80 or 82 added. The separate code(s) would be reported without modifier 62 added.

## Procedure Performed on Infants Less Than 4 kg—Modifier 63

**Modifier 63** reports procedures performed on neonates and infants up to a body weight of 4 kg. This modifier is not to be appended to codes from the Evaluation and Management section, Anesthesia section, Radiology section, Pathology/Laboratory section, or Medicine section. As per the definition in Appendix A of the CPT manual, this modifier is to be used on codes 20100–69990, unless otherwise designated in the manual.

**EXAMPLE:** Tiny Tim, a 3.6-kg male infant, underwent a repair of a congenital arteriovenous fistula of the thorax and abdomen.

This procedure would be reported with code 35182-63 because of the weight of the child.

## Surgical Team—Modifier 66

Some highly complex procedures require the services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment during the operative procedure. When this occurs, it is known as the *surgical team* concept. To indicate this on the claim, each provider should append **modifier 66** to the basic procedure number used for reporting services.

**EXAMPLE:** Mr. Daniels underwent the repair of some complex cardiac anomalies by the modified Fontan procedure. It was also necessary to perform a cavopulmonary anastomosis to a second superior vena cava. It was necessary for several cardiothoracic surgeons to work together as a team to accomplish this procedure successfully.

Codes 33617 and 33768 would be used to report this procedure. A 66 modifier is appended to the services to indicate the surgery was performed by a team of surgeons, not just one or two. Each surgeon would need to document the procedure, indicating the need for a team of surgeons, unless one op note can clearly delineate each surgeon's role in the procedure.

## Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia—Modifier 73

**Modifier 73** is used for outpatient or ambulatory surgery centers and is used when, due to extenuating circumstances or situations that threaten the well-being of the patient, the physician cancels a surgical or diagnostic procedure after the patient's surgical preparation. The preparation includes sedation, when provided, and being taken to the room where the procedure is to be performed; however, the surgery is cancelled prior to the administration of anesthesia. Under these circumstances, the procedure code for the intended procedure is used and appended with modifier 73.

**EXAMPLE:** Mrs. Evans was wheeled into the OR for her breast biopsy. As she was being prepped, minutes prior to the administration of the anesthesia, there was a mechanical problem with the electrical power to the operating room. The generator was not responding, and the other operating rooms were being utilized. The surgeon had to cancel the surgery until a later date.

It should be noted that modifier 73 is not used for the elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient.

## Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia—Modifier 74

Like modifier 73, **modifier 74** is used for outpatient or ambulatory surgery centers. Modifier 74 is used when, due to extenuating circumstances or those that threaten the well-being of the patient, the physician terminates a surgical or diagnostic procedure *after* the administration of anesthesia or after the procedure was started. Modifier 74 is appended to the usual procedure code for the intended procedure.

## Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional—Modifier 76

At times, it is necessary for a physician or other qualified health care professional to repeat a procedure or service subsequent to the original procedure or service. When this occurs, **modifier 76** is used. The original procedure or service code is the same for both sessions.

**EXAMPLE:** Mrs. Roberts underwent a needle thoracentesis aspiration of the pleural space by Dr. Clark. Later that day, another thoracentesis was necessary, and Dr. Clark performed it.

Dr. Clark reported the second procedure with code 32554-76. Note that this modifier is not to be appended to an E/M code.

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

**Modifier 77** is used when a physician or other qualified health care professional needs to indicate that a basic procedure or service performed by another physician had to be repeated. The physician who repeated the procedure would append modifier 77 to the repeated procedure or service code, which would be the same procedure or service code as the original procedure or service code. By slightly modifying our previous example, we can see how to use modifier 77:

**EXAMPLE:** Mrs. Roberts underwent a needle thoracentesis aspiration of the pleural space by Dr. Clark. The next day, another needle thoracentesis aspiration of the pleural space was necessary; however, Dr. Clark was not available. Dr. Lewis performed the procedure.

Dr. Lewis reported it with code 32554-77. This modifier is not be be appended to an E/M code.

## Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period—Modifier 78

At times, a patient is taken back to the operating room for a *related* procedure during the postoperative period of the initial procedure. The claim would indicate that another procedure was performed during the postoperative period of the initial procedure by appending **modifier 78** to the procedure code of the subsequent procedure. It is possible that an unforeseen complication may arise from the original surgery and that the patient may need to be returned to the operating room.

**EXAMPLE:** Mr. Mitchell had hip replacement surgery performed by Dr. Weiss. Two days postop, the incision developed a hematoma. This required a return trip to the OR, where Dr. Weiss performed a superficial wound dehiscence with a simple closure.

To report this service properly, you would use code 12020-78. Should documentation be requested by a payer, it needs to support the use of this modifier.

## Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period—Modifier 79

During a postoperative period, it may be necessary for the performance of another procedure that was unrelated to the original procedure. When this situation occurs, **modifier 79** is used.

**EXAMPLE:** Mr. Duncan underwent an excision of two lesions on the small intestine by Dr. Cass. Mr. Duncan was experiencing pain in the area of the diaphragm 30 days postop. Several tests were done, and a diaphragmatic hernia was diagnosed. Mr. Duncan underwent surgical repair of a paraesophageal hiatal hernia via thoracotomy.

Dr. Cass reported code 43334-79.

## Assistant Surgeon—Modifier 80

During surgery, it is not uncommon for a surgeon to assist another surgeon. To report the services of the assistant surgeon, add modifier 80 to the usual procedure code. The assistant surgeon reports the same code(s) as the primary surgeon, but a **modifier 80** is added to his or her services.

**EXAMPLE:** Dr. Barton performed an anastomosis on the extrahepatic biliary ducts and gastrointestinal tract. Dr. Carrey assisted Dr. Barton with this procedure.

In our example, Dr. Barton would bill code 47780, whereas Dr. Carrey would report 47780-80 for his services.

It should be noted that Medicare Part B does not cover the services of an assistant surgeon for certain procedures. The physician fee schedule on the CMS Web site lists the modifier 80 exemptions. Payment cannot be collected from the patient for these services if the provider is enrolled as a participating Medicare provider.

## Minimum Assistant Surgeon—Modifier 81

**Modifier 81** would be used if the circumstances required a second surgeon for a short time, but not throughout the whole procedure. Another instance that would warrant an 81 modifier would be when a second or third assistant surgeon was needed during a procedure.

**EXAMPLE:** Dr. Grace was performing an open revision of arteriovenous fistula with an autogenous dialysis graft with thrombectomy. At one point, he required the assistance of Dr. Brown to help with some bleeding. Dr. Grace got the patient stable and finished the procedure. Dr. Brown was present only during the critical portion of the surgery and left the surgical suite after the patient stabilized.

Dr. Grace would report his services with CPT code 36833, whereas Dr. Brown would report his services with code 36833-81.

## Assistant Surgeon (When Qualified Resident Surgeon Is Not Available in a Teaching Facility)—Modifier 82

**Modifier 82** is used when there is the unavailability of a qualified resident surgeon. In the teaching hospital setting, some residency programs allow their residents to participate as assistants-at-surgery. Modifier 82 is appended if a qualified resident surgeon is not available. CMS guidelines require a certification on file for each claim submitted with this modifier as part of section 1842 of the Social Security Act.

**EXAMPLE:** Dr. Evans was the surgeon on call at 3:00 a.m. when four people were brought into Mercy Hospital, a teaching facility. The four patients had been seriously injured in a motor vehicle accident. All four patients needed immediate surgical attention, which left the surgical teams shorthanded. Dr. Evans asked a colleague in his practice, Dr. Donaldson, to assist because all the surgical residents were caring for other patients.

Dr. Donaldson's services are reported with an 82 modifier to indicate that no surgical residents were available to assist Dr. Evans.

## Reference (Outside) Laboratory—Modifier 90

**Modifier 90** is used on laboratory procedure codes to indicate that the laboratory procedures are performed by a party other than the treating or reporting physician.

**EXAMPLE:** Dr. McGuire ordered a urine culture to be done on a patient who he suspected had a bladder infection but who was sensitive to certain antibiotics. The culture was to be done by an outside laboratory because Dr. McGuire's lab does not perform cultures.

The urine culture would be reported with a 90 modifier to indicate that the test was sent out to be run.

## Repeat Clinical Diagnostic Laboratory Test—Modifier 91

**Modifier 91** is used to indicate that the same laboratory test was repeated on the same day to obtain subsequent (multiple) test results. Problems with equipment or collected specimen, confirmation of initial test results, and the availability of an all inclusive code are *not* considered valid reasons to append this modifier.

**EXAMPLE:** Jenny presented to her physician with a blood sugar reading of 325. Jenny had a quantitative blood glucose test in the doctor's office, which confirmed her high blood sugar reading. She was given Glucophage, p.o., right then in the office. The physician asked her to wait for an hour, and the test was rerun, with results showing Jenny's blood sugar back in a more acceptable range.

The first test would be reported with code 82947, and the second with code 82947-91.

It should also be noted that this modifier is not used when the code description includes a series of test results that are run on the same day.

## Alternative Laboratory Platform Testing—Modifier 92

**Modifier 92** is used when laboratory testing is performed by the use of a kit or transportable instrument for HIV testing: codes 86701–86703 and 87389. The kit's components can include a single-use, disposable analytical chamber, which can be carried or transported to the vicinity of the patient.

**EXAMPLE:** The family planning clinic of the Northeast is conducting HIV screening testing at a college campus using a transportable instrument. The staff is using a finger-stick blood sample to test for HIV-1.

The code used to report the HIV-1 test is code 86701-92.

## Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System—Modifier 95

**Modifier 95** is used to report synchronous telemedicine services that occur using a real-time interactive audio and video telecommunications system. This modifier can only be appended to services that are listed in Appendix P of the CPT manual. The CMS HCPCS modifier GT (defined as via interactive audio and video telecommunication systems) also currently exists to report telemedicine services to Medicare, but the GT modifier is not accepted by all payers. Modifier 95 was added to provide for the reporting of telemedicine services for payers that do not accept the GT modifier.

When using the 95 modifier the following criteria must be met:

1. The CPT code that is to be reported is listed in appendix P of the CPT manual and the telemedicine star icon appears next to the CPT code description in the CPT manual. (Reference the code description for code 99214 in the CPT manual and in Appendix P of the CPT manual to see how this displays in the CPT manual.)
2. All components of the CPT code description are completed via telemedicine and are documented by the provider of service.
3. A real-time audio and video telecommunication system is used and the provider and patient are in different locations when the service is performed.

**EXAMPLE:** Dr. Jones performed services reported by code 99214 via telemedicine services. Dr. Jones is in his office and the patient is 5 miles from his office at a skilled nursing facility. Code 99214-95 is the correct code to report to a payer that accepts the 95 modifier but not the GT modifier.

Remember, prior to using the 95 modifier you must determine that the code may be used for synchronous telemedicine services.

## Habilitative Services—Modifier 96

There are services and procedures that are completed for either habilitative or rehabilitative purposes. For example physical or occupational therapies are such services. **Modifier 96**, is be used by a physician or other qualified health care professional, to denote when a service or procedure is provided for habilitative purposes.

Within the CPT manual habilitative services are defined as services that teach an individual learned skills and functions for daily living that the individual has not yet developed. The habilitative services will then additionally help the individual to maintain and improve the learned skills or also help the individual maintain, learn, or improve skills and functioning for daily living.

## Rehabilitative Services—Modifier 97

**Modifier 97** is used to denote services or procedures that are rehabilitative in nature and can be used by a physician or other qualified health care professional. Rehabilitative services are services that occur after an individual was sick, hurt, or disabled. The purpose of the rehabilitative service is to help the individual maintain, get back, or improve skills and functions for daily living that were impaired or lost due to the sickness, injury, or a disability that the individual sustained.

## Multiple Modifiers—Modifier 99

Under certain circumstances, more than two modifiers may be necessary to delineate a service completely. When more than two are necessary, modifier 99 is used.

**EXAMPLE:** Marty presented to Dr. Taggert for treatment of his mycotic nails. He had the great toe on both feet treated, as well as the fourth and fifth toes on the right, and the third and fourth toes on the left.

Dr. Taggert would report his treatment of mycotic nails, code 11721, with the modifiers for the toes that were treated: TA, T2, T3, T5, T8, T9. Since all these modifiers will not fit in the modifier field, the use of modifier 99 would be appropriate. To report this on a claim, most insurance companies require the 99 modifier in the first field, followed by the next three modifiers and the remaining modifiers in the narrative.

# HCPCS Level II Modifiers

HCPCS Level II modifiers accompany the HCPCS Level II codes. The Healthcare Common Procedure Coding System (HCPCS) is an alphanumeric system that describes services provided by physicians and other providers. The HCPCS system also provides codes for ambulance and durable medical equipment (DME). DME services include such things as crutches, walkers, and canes. These codes may or may not be reimbursed. The coder, as well as the providers, needs to know that just because a CPT code for a service exists does not mean that the service is reimbursable. This is something that the insurance carriers should be contacted about. More details about the HCPCS code set are explained later in this textbook.

HCPCS modifiers are assigned for the same reason that the other modifiers are assigned: the service being provided needs to be explained further. The author referenced the HCPCS Level II modifier information at *http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html.* Listed below are some of the modifiers that are used. The list is not exhaustive. Coders should use the Web sites of the various insurance carriers, as well as the CMS site for clarification on usage of these modifiers. A comprehensive list is found in Appendix 2 of the HCPCS Level II book. The purpose of the following partial listing of Level II HCPCS modifiers is to provide an overview of the use and types of Level II modifiers that are used when reporting HCPCS Level II codes.

## Level II—HCPCS Alphanumeric Modifiers

The following is a partial list of the Level II HCPCS modifiers:

**A1**—Dressing for 1 wound.

**A2**—Dressing for 2 wounds.

**A3**—Dressing for 3 wounds.

**A4**—Dressing for 4 wounds.

**A5**—Dressing for 5 wounds.

**A6**—Dressing for 6 wounds.

**A7**—Dressing for 7 wounds.

**A8**—Dressing for 8 wounds.

**A9**—Dressing for 9 or more wounds.

**AA**—Anesthesia services performed by anesthesiologist.

**AD**—Medical supervision by a physician, more than four concurrent anesthesia procedures.

**AE**—Registered Dietician.

**AF**—Specialty Physician.

**AG**—Primary Physician.

**AH**—Clinical Psychologist (CP) services. [Used when a medical group employs a CP and bills for the CP's service.]

**AI**—Principal physician of record.

**AJ**—Clinical Social Worker (CSW). [Used when a medical group employs a CSW and bills for the CSW's service.]

**AK**—Nonparticipating Physician.

**AM**—Physician, team member service.

**AP**—Determination of refractive state not performed in the course of diagnostic ophthalmological examination.

**AQ**—Physician providing a service in an unlisted health professional shortage area (HPSA).

**AR**—Physician Provider Services in a Physician Scarcity Area (PSA). [Effective for dates of service on or after January 1, 2005.]

**AS**—Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant at surgery.

**AT**—Acute treatment. (This modifier should be used when reporting a spinal manipulation service [codes 98940, 98941, and 98942].) Effective dates of service October 1, 2004, and after.

**CC**—Procedure code changed. [This modifier is used when the submitted procedure code is changed either for administrative reasons or because an incorrect code was filed.]

**CR**—Catastrophe/disaster related.

**EJ**—Subsequent claims for a defined course of therapy (example: EPO, sodium hyaluronate).

**EM**—Emergency reserve supply (for ESRD benefit only).

**EP**—Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program.

The following modifiers are used to identify various body parts that might need to be identified when multiple procedures are reported.

**E1**—Upper Left, Eyelid.

**E2**—Lower Left, Eyelid.

**E3**—Upper Right, Eyelid.

**E4**—Lower Right, Eyelid.

**FA**—Left Hand, Thumb.

**F1**—Left Hand, Second Digit.

**F2**—Left Hand, Third Digit.

**F3**—Left Hand, Fourth Digit.

**F4**—Left Hand, Fifth Digit.

**F5**—Right Hand, Thumb.

**F6**—Right Hand, Second Digit.

**F7**—Right Hand, Third Digit.

(*continues*)

(*continued*)

**F8**—Right Hand, Fourth Digit.

**F9**—Right Hand, Fifth Digit.

**LM**—Left Main Coronary Artery.

**LT**—Left Side. [Used to identify procedures performed on the left side of the body.]

**RC**—Right Coronary Artery.

**RI**—Ramus Intermedius Coronary Artery.

**RT**—Right Side. [Used to identify procedures performed on the right side of the body.]

**TA**—Left Foot, Great Toe.

**T1**—Left Foot, Second Digit.

**T2**—Left Foot, Third Digit.

**T3**—Left Foot, Fourth Digit.

**T4**—Left Foot, Fifth Digit.

**T5**—Right Foot, Great Toe.

**T6**—Right Foot, Second Digit.

**T7**—Right Foot, Third Digit.

**T8**—Right Foot, Fourth Digit.

**T9**—Right Foot, Fifth Digit.

## Additional Modifiers F to G9

The following is a partial listing of the F to G9 modifiers. Modifiers G1 to G6 are used to report information about dialysis services. End Stage Renal Disease (ESRD) facilities report CPT code 90999 (unlisted dialysis procedure), and one of the G modifiers (G1, G2, G3, G4, and G5) on all claims for hemodialysis to reflect the most recent urea reduction ratio (URR). Medicare reviews the reported G1 to G5 modifier to determine the adequacy of dialysis to measure the quality of dialysis services. Code 90999-G6 reports to Medicare that less than six dialysis sessions have been provided in a month.

**FP**—Service provided as part of Medicaid Family Planning Program.

**FX**—X-ray taken using film.

**G1**—Most recent urea reduction ratio (URR) reading of less than 60.

**G2**—Most recent urea reduction ratio (URR) reading of 60 to 64.9.

**G3**—Most recent urea reduction ratio (URR) of 65 to 69.9.

**G4**—Most recent urea reduction ratio (URR) of 70 to 74.9.

**G5**—Most recent urea reduction ratio (URR) reading of 75 or greater.

**G6**—ESRD patient for whom less than six dialysis sessions have been provided in a month.

**G7**—Pregnancy resulted from rape or incest, or pregnancy is certified by physician as life threatening.

**G8**—Monitored Anesthesia Care (MAC) for deep complex, complicated, or markedly invasive surgical procedure.

**G9**—Monitored Anesthesia Care (MAC) for patient who has history of severe cardio-pulmonary condition.

## G Modifiers

Knowledge of the following G modifiers is important if you are reporting services for Medicare patients; use of these modifiers will help prevent Medicare payment denials and allows for the proper payment of Medicare claims.

**GA**—Waiver of Liability Statement on file. [Effective for dates of service on or after October 1, 1995, a physician or supplier should use this modifier to note that the patient has been advised of the possibility of noncoverage.]

**GC**—This service has been performed in part by a resident under the direction of a teaching physician.

**GE**—This service has been performed by a resident without the presence of a teaching physician under the primary care exception.

**GG**—Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day.

**GH**—Diagnostic mammogram converted from screening mammogram on same day.

**GJ**—"Opt Out" physician or practitioner emergency or urgent service.

**GM**—Multiple patients on one ambulance trip.

**GN**—Services delivered under an outpatient speech language pathology plan of care.

**GO**—Services delivered under an occupational therapist plan of care.

**GP**—Services delivered under a physical therapist plan of care.

**GQ**—Via asynchronous telecommunications system.

**GT**—Via interactive audio and video telecommunication systems.

**GV**—Attending physician not employed or paid under arrangement by the patient's hospice provider.

**GW**—Service not related to the hospice patient's terminal condition.

**GY**—Item or service statutorily excluded or does not meet the definition of any Medicare benefit.

**GZ**—Item or service expected to be denied as not reasonable and necessary.

## Modifiers J through V

The following is a partial list of modifiers J to V. A complete listing of modifiers J to V is found in the HCPCS Level II manual. This partial listing helps to outline the types of modifiers that are found in this range of modifiers.

**J1**—Competitive Acquisition Program (CAP), no-pay submission for a prescription number.

**J2**—Competitive Acquisition Program (CAP), restocking of emergency drugs after emergency administration and a prescription number.

**J3**—Competitive Acquisition Program (CAP), drug not available through CAP as written, reimbursed under average sales price (ASP) methodology.

**KL**—DMEPOS item delivered via mail.

**KO**—Single drug unit dose formulation.

**KP**—First drug of a multiple drug unit dose formulation.

**KQ**—Second or subsequent drug of a multiple drug unit dose formulation.

**KX**—Therapy cap exception has been approved, or it meets all the guidelines for an automatic exception.

(*continues*)

(*continued*)

**LC**—Left circumflex coronary artery.

**LD**—Left anterior descending coronary artery.

**LR**—Laboratory round-trip.

**LS**—FDA-monitored intraocular lens implant.

**Q3**—Live kidney donor and related services.

**Q4**—Service for ordering/referring physician qualifies as a service exemption.

**Q5**—Service furnished by a substitute physician under a reciprocal billing arrangement.

**Q6**—Service furnished by a locum tenens physician.

**Q7**—One Class A finding.

**Q8**—Two Class B findings.

**Q9**—One Class B and Two Class C findings.

**QA**—FDA investigational device exemption.

**QB**—Physician providing service in a rural Health Professional Shortage Area (HPSA).

**QC**—Single channel monitoring.

**QD**—Recording and storage in solid-state memory by digital recorder.

**QK**—Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.

**QL**—Patient pronounced dead after ambulance called.

**QM**—Ambulance service provided under arrangement by a provider of services.

**QN**—Ambulance service furnished directly by a provider of services.

**QP**—Documentation is on file showing that the laboratory test(s) was ordered individually or ordered as a CPT-recognized panel other than automated profile codes 80002–80019, G0058, G0059, and G0060.

**QS**—Monitored anesthesia care service.

**QT**—Recording and storage on a tape by an analog tape recorder.

**QW**—Clinical Laboratory Improvement Amendment (CLIA) waived test. (Modifier used to identify waived tests.)

**QX**—CRNA service with medical direction by a physician.

**QY**—Anesthesiologist medically directs one CRNA.

**QZ**—CRNA service without medical direction by a physician.

**RD**—Drug provided to beneficiary but not administered "incident to."

**SF**—Second opinion ordered by a Professional Review Organization (PRO) per Section 9401, P.L. 99-272 (100% reimbursement—no Medicare deductible or coinsurance).

**SG**—Ambulatory Surgical Center (ASC) facility service.

**SL**—State supplied vaccine.

**SW**—Services provided by a Certified Diabetic Educator.

**SY**—Persons who are in close contact with member of high-risk population (use only with codes for immunizations).

**TC**—Technical Component. Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances, adding modifier TC to the usual procedure number identifies the technical component charge. **Note:** The TC modifier should not be appended to procedure codes that represent the technical component (e.g., 93005).

**TG**—Complex/higher level of care.

**UN**—Two patients served.

**UP**—Three patients served.

**UQ**—Four patients served.

**UR**—Five patients served.

**US**—Six or more patients served.

**VP**—Aphakic patient.

## Ambulance Origin and Destination Modifiers

The following modifiers are used to designate the place of origin and destination of a transport. The first position identifies the place of origin, and the second position identifies the destination.

**EXAMPLE:** A patient is picked up at the scene of an accident and transported to a hospital. Place "S" (scene of accident or acute event) in the first modifier position to indicate the place of origin. Place "H" (hospital) in the second modifier position to indicate the destination of the patient.

**D**—Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes.

**E**—Residential, domiciliary, custodial facility (other than an 1819 facility).

**G**—Hospital Based ESRD facility.

**H**—Hospital.

**I**—Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport.

**J**—Free-standing ESRD facility.

**N**—Skilled Nursing Facility.

**P**—Physician's office.

**R**—Residence.

**S**—Scene of Accident or Acute Event.

**X**—Intermediate stop at physician's office on the way to the hospital (Destination code only).

# Summary

- Modifiers offer additional information to insurance payers and Medicare to release payment for services.
- Modifiers work as adjectives in describing services provided to patients.
- Some modifiers affect payment.
- Some modifiers are for information only.
- Modifiers indicate that additional information may be found in the supporting documentation.
- The two types of modifiers are CPT Level I modifiers and HCPCS Level II modifiers.

# Internet Links

For federal regulatory information about physician billing and payment, go to ***http://www.cms.gov*** and search physician billing.

# Chapter Review

## Fill in the Blank

**Instructions:** Fill in the blanks in the statements that follow.

1. A CPT modifier is a(n) _____ digit modifier appended to a CPT code to indicate that a service or procedure has been altered.
2. A complete listing of Level I modifiers commonly found in the CPT coding book can be found in _____.
3. When billing physician services, place modifiers in item _____ of the CMS-1500 form.
4. Statistical modifiers, also known as _____ modifiers, are used for informational purposes and affect the processing or payment of the code billed but do not affect the fee.
5. Modifier 99 indicates that _____ modifiers are needed for an individual CPT code.
6. Modifier 56 is used only when _____ management is provided.
7. A mandated service is reported using modifier _____.
8. When a surgeon completes only the surgical care, modifier _____ should be appended to the CPT procedure code.
9. To report the services of the assistant surgeon, add modifier _____ to the procedure code.
10. Modifier 90 is used on _____ laboratory or reference laboratory procedure codes to indicate that the procedure was performed by a party other than the treating or reporting physician.

## Identify the Modifier

**Instructions:** For the following situations, list the correct modifier to use, or supply a short answer.

1. Two surgeons _____
2. Unusual anesthesia _____
3. Increased procedural services _____
4. Reduced services _____
5. Postoperative management only _____
6. Explain when modifier 26 is used. _____
7. Explain when modifier 47 is used. _____
8. When a bilateral procedure is performed in the same operative session and the CPT code describes a unilateral procedure, which modifier should be appended to the CPT code? _____
9. Which modifier is used to indicate that a different provider performed the preoperative procedure management of a patient? _____

10. Repeat procedure or service by the same physician or other qualified health care professional _____
11. Discontinued procedure _____
12. Decision for surgery _____
13. Surgical team _____
14. Assistant surgeon _____
15. Professional component _____
16. What modifier would be added to code 90999 to indicate that a patient's most recent URR reading was 61.4? _____
17. Right hand, fourth digit _____
18. Multiple patients were transported on one ambulance trip. Which modifier should be appended to the service code? _____
19. Minimum assistant surgeon _____
20. Repeat clinical diagnostic laboratory test _____

# Case Studies

Review each case and indicate the correct code(s).

## Case 1

Marty went to the doctor's office with a sore throat and an upset stomach. The doctor performed an exam and evaluation of Marty. In the course of the evaluation, Marty mentioned he was having some back pain. The doctor also evaluated this issue and performed an osteopathic manipulation on one body region. The doctor reported a 99213 with a(n) _____ modifier and a 98925 for the OMT.

## Case 2

Dr. Albert is performing a complicated pyeloplasty on Kelly. Kelly was tolerating the procedure fairly well until her blood pressure began to drop dangerously low. After having trouble stabilizing her, Dr. Albert discontinued the procedure because he felt it would be too dangerous to continue. The doctor reported the part of the service he performed with a 50400 and a(n) _____ modifier.

## Case 3

Jamie South was out of town playing football two weeks ago, and he sustained a broken ankle. He was taken to the local hospital, and Dr. Books performed a closed treatment of trimalleolar ankle fracture with manipulation. Today he is being seen by Dr. Thompson for the postoperative care for the fracture treatment. Dr. Thompson should report code 27818 with modifier _____.

## Case 4

Mary Beth is a 19-day-old neonate who weighs 3.2 kg and who is undergoing an arthrotomy with biopsy of the interphalangeal joint. The surgeon reports code 28054 with modifier _____.

## Case 5

Dr. Cook is performing a pulmonary valve replacement. Dr. Samson is the assistant surgeon for the case. Dr. Cook reports code 33475, whereas Dr. Samson should report _____.

## Case 6

Sam is a 10-year-old child who has had chronic ear infections for the last year. Today Dr. Abbes has decided that Sam needs to have tubes inserted into his ears. This is scheduled to occur in three weeks. Today's visit was coded with 99214 appended with modifier _____.

## Case 7

James Tree is a patient at an intermediate care facility. Today he is being seen by Dr. Rip because of a state mandate for the resident to be seen every six months. Code 99309 was reported with modifier _____ to report the mandated service.

## Case 8

Dr. Whoo interprets an MRI of the temporomandibular joint. This is reported with code 70336, appended with modifier _____.

## Case 9

Drs. Jones and Smith work as a surgical team to perform a double lung transplant with cardiopulmonary bypass. Dr Jones would report code 32854, and Dr. Smith would report code 32854-66. Is this correct? _____

## Case 10

Dr. Jackson performed a therapeutic pneumothorax on Sally Small and reported code 32960. Later that same day, the procedure was repeated by Dr. Jackson. How should the second procedure be reported? _____