Summary of Medicare Global Surgery Modifiers

Modifier	Definition	Comments
22	Increased Procedural Services	• Modifier 22 indicates that the work to provide the surgery is substantially greater than that usually required. • Append modifier 22 to the CPT code for the procedure performed. • The documentation in the operative report must support the additional work and the reason for the additional work. This might be due to increased intensity, time, technical difficulty, severity of the patient's condition, or physical and mental effort required. Separate documentation containing a concise statement about how the service differs from the usual may be necessary. • Modifier 22 should not be appended to an E/M code.
24	Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period	• Modifier 24 indicates the physician performed an unrelated E/M service during the post-operative period (0,10,90 day global) • Append modifier 24 to the appropriate level of E/M service • Documentation must support that the E/M visit is unrelated to the post-operative care of the procedure. Documentation of a different ICD-9 code from the original procedure that clearly indicates the reason for the encounter was unrelated to surgical postoperative care is usually sufficient. • Modifier 24, if sufficiently documented, can be reported when an E/M service is exclusively for treatment of the underlying condition and not for post-operative care. • Physicians who are managing chemotherapy during the post-operative period of a procedure may bill for the E/M service with modifier 24. ICD-9-CM V58.1 may be appropriate to document the need for this service. • Physicians who are counseling the patient in the post-operative period on chemotherapy and/or radiation may bill for the E/M service with modifier 24. ICD-9-CM V65.49 may be appropriate to document the need for this service. • Do not use modifier 24 on the same day as a procedure or to document treatment of a wound infection.

Modifier	Definition	Comments
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service	• Modifier 25 indicates the patient's condition on the day of the procedure required a significant, separately identifiable E/M service beyond the usual preoperative and post-operative care associated with the procedure or service performed. • Append modifier 25 to the appropriate level of E/M service • Documentation should substantiate the relevant criteria for the reported E/M code along with the documentation of the procedure. • Modifier 25 should be used when the procedure has a global period of 0 or 10 days. • Modifiers 24 and 25 should both be reported when a significant, separately identifiable E/M service on the day of a procedure falls within the post-operative period of another unrelated procedure

50	Bilateral Procedure	• Modifier 50 indicates that the same unilateral procedure (same CPT code) is performed on both sides of the body during the same operative session or on the same day.
		
		• Append modifier 50 to the CPT code for the procedure performed.
		
		• Modifier 50 should not be reported when the code descriptor indicates the procedure is bilateral nor when the code descriptor indicates it can be reported either unilaterally or bilaterally.
		
		• *The Medicare Physician Fee Schedule Data base indicates which procedures Medicare accepts with a modifier 50.
		  - "0" indicates a unilateral code; modifier 50 is not billable
		  - "1" indicates; modifier 50 can be appropriate.
		  - "2" indicates a bilateral code; modifier 50 is not billable.
		  - "3" indicates primary radiology codes; modifier 50 is billable.
		  - "9" indicates that the concept does not apply (office visit)

Modifier	Definition	Comments
51	Multiple Procedures	• Modifier 51 indicates that additional procedure(s), other than those services that are normally a usual and necessary part of the surgical procedure, were performed by the same provider at the same session as a primary surgical procedure. • Append modifier 51 to the lesser valued procedure(s) • Documentation should support that the lesser procedure(s) was not integral to the performance of the primary procedure. • The primary procedure is the one with the highest RVU. • A multiple procedure discount will be applied to the lesser procedures. • Modifier 51 should not be appended to add-on codes, modifier 51 exempt codes, E/M codes, physical medicine and rehab services, or supplies. • Some Medicare carriers prefer the modifier not be submitted by the physician.
52	Reduced Service	• Modifier 52 indicates that the service or procedure performed was partially reduced from that usually performed. • Append modifier 52 to the CPT code for the furnished service and reflect why the procedure was different from the usual. • Documentation should reflect actual service performed. • Modifier 52 should not be reported if there is another CPT code that describes the specific service performed.
53	Discontinued Procedure	• Modifier 53 indicates the physician elected to terminate a surgical or diagnostic procedure due to extenuating circumstances, or those threatening the well-being of the patient. • Append modifier 53 to the CPT code for the discontinued procedure. • Documentation should reflect the extent of the procedure performed and the reason the procedure was discontinued. • It may be reported for both office and hospital based procedures. • It should not be reported for elective cancellation of a procedure prior to anesthesia induction or surgical prep. • It should not be used to when a surgical approach is unsuccessful and another approach during the same

		session is completed.

Modifier	Definition	Comments
54	Surgical Care Only	• Modifier 54 indicates the surgeon is relinquishing all or part of the postoperative care to a physician outside the same group. • Append modifier 54 to the CPT code describing the surgical service. • Applicable only to codes with a 010 or 090 global periods • Documentation should reflect the surgical procedure provided and the plans for post-operative care
55	Postoperative Management Only	• Modifier 55 indicates that a physician other than the surgeon furnished outpatient postoperative care. • Append modifier 55 to the CPT code describing the surgical procedure • Applicable only to codes with 10 or 90 day global periods • Documentation should support that outpatient postoperative services were provided and that an agreement was entered into with the surgeon for post-operative care. • Services cannot be reported until at least one post-operative service has been provided.
57	Decision for Surgery	• Modifier 57 indicates that an E/M service provided the day prior or the day of a major procedure (90 day global) resulted in the initial decision to perform the surgery. This E/M service is not included in the global surgery payment and is separately billable. • Append modifier 57 to the appropriate level of E/M service code. • Documentation should clearly indicate when the initial decision to perform the surgery was made. • Modifier 57 should only be reported in connection with major surgical procedure having a 90-day global period. • Modifier 57 should not be reported for preplanned or prescheduled surgeries, or if the surgical procedure indicates performance in multiple sessions or stages.

Modifier	Definition	Comments
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period	- Modifier 58 indicates the procedure was: - Planned prospectively at the time of the original procedure - More extensive than the original procedure. - For therapy following a diagnostic surgical procedure. - Append modifier 58 to the code for the subsequent procedure performed - Documentation should support the procedure performed - Modifier 58 should not be reported if the subsequent procedure is clearly unrelated to the original surgery - A new global period is initiated
59	Distinct Procedural Service	- Modifier 59 indicates a procedure or service was distinct or separate from other services performed on the same day. It indicates that the services are not usually encountered or performed on the same day by the same individual. This may be represented by a: - different session or patient encounter - different procedure or surgery - different site - separate session or - separate injury (or area of injury) **Append modifier 59 to the secondary, additional, or lesser procedure. For CCI, this is the column 2 code. - Documentation should clearly support the distinct nature of the procedures. - Modifier 59 should be used if only no other valid modifier exists. - Modifier 59 is not valid on E/M Codes
62	Two Surgeons	- Modifier 62 indicates that two surgeons worked together as primary surgeons performing distinct parts of a procedure described by a CPT code. - Append modifier 62 to each surgeon's claim reported with the same CPT code. - Documentation by each physician should support the performance of a distinct portion of the procedure he/she accomplished. - Reimbursement is 62.5% of the allowable amount to each surgeon if they are of different specialties. - Reimbursement to surgeons of the same specialty will be made only after review for medical necessity. *Only certain procedure codes are eligible for reimbursement using modifier 62. These are identified

		on the Medicare Physician Fee Schedule Database.

Modifier	Definition	Comments
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period	• Modifier 78 indicates the performance of a procedure during the postoperative period or on the same day as the original procedure to treat complications which required a return to the operating/procedure room • Append modifier 78 to the CPT code describing the procedure(s) performed during the return trip. • Documentation should support the CPT code performed and the reason for the return to the operating/procedure room. • An operating/procedure room is defined by Medicare as any place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, laser suite, or endoscopy suite. It does not include a patient's room, minor treatment room, recovery room, or intensive care unit. • Postoperative care for the procedure is included in the payment for the original procedure. A new global period is not initiated for the procedure reported with the 78 modifier. • Modifier 78 should be used to document treatment of complications only. • Reimbursement for procedures reported with modifier 78 is for the intra-operative percentage only.
79	Unrelated Procedure or Service by the Same Physician During the Postoperative Period	• Modifier 79 indicates the performance of a procedure or service during a post-operative period was unrelated to the post-operative care of the original procedure. • Append modifier 79 to the procedure performed. • Documentation should support the procedure code reported. Documentation of a different ICD-9-CM code from the original procedure is usually sufficient to support that the procedure is unrelated to the original procedure. • A new global period is initiated for the procedure reported with modifier 79.

Modifier	Definition	Comments
80	Assistant Surgeon	• Modifier 80 indicates that a surgical assistant was involved in the case. • Append modifier 80 only to the claim for the assistant-at-surgery. • Documentation by the primary surgeon indicating the presence of the assistant is sufficient. • Reimbursement is 16% of the allowable amount for the assistant surgeon. • *Only certain procedure codes are eligible for reimbursement using modifier 80. These are identified on the Medicare Physician Fee Schedule Database.

82	Assistant Surgeon When Qualified Resident is Not Available	• Modifer 82 indicates that a teaching physician provided assistant-at-surgery services in a teaching institution because a qualified resident was not available.
		• Modifier 82 is appended to the CPT code for the surgery performed on the teaching physician's claim.
		• Payment can be made to the teaching physician when:
		  - An exceptional medical circumstance exists OR
		  - The primary surgeon has an across-the-board policy of never involving residents in the care of his/her patients OR
		  - Other specific situations involving numbers and qualifications of residents or types of surgery performed
		• The primary surgeon must complete an attestation statement verifying that a qualified resident was not available. This statement should be retained in a file.

AS	Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist Services for Assistant-at-Surgery	• Modifier AS indicates that a non-physician provider (NPP) served as an assistant-at-surgery. • Modifier AS is appended to the CPT code for which assistant-at-surgery services were provided • Documentation by the primary surgeon indicating the presence of the assistant is sufficient. • The service must be billed using the NPP's Medicare provider number (NPI) • Reimbursement is at 85% of the allowable amount for a physician.

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