AMA Disclaimer

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The most common modifiers used with evaluation and management services include:

- Modifier 24 Unrelated evaluation and management service by the same physician during a postoperative period.
- Modifier 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.
- Modifier 32 Mandated services
- Modifier 57 Decision for surgery

To accurately apply many of the modifiers, it is important to understand the concept of a global surgical package.

**The Global Surgical Package**

The “Surgery Guidelines” within the CPT® codebook lists those services that CPT® includes in the global surgical package, such as one pre-procedure E/M service on the day of, or day before, the procedure, local anesthesia, and immediate and typical postoperative care. Medicare’s list of items included in the global package is more extensive.

CPT® does not specify the length of the postoperative period for any individual procedure, whereas CMS defines very precisely—in the Physician Fee Schedule Relative Value File, which is updated annually—the number of postoperative days assigned to each code. Minor surgeries are assigned 000 or 010 global days. Major surgeries are assigned 090 global days.

Because the CPT® codebook and CMS define the components of the global surgical package differently, and third-party payer guidelines are inconsistent, you should check with your individual payer to determine its rules for the global surgical package.

**Modifier 24**

Modifier 24 is to be used when patient is seen by the same physician or another physician of the same specialty who belongs to the same group practice during a postoperative period for an unrelated evaluation and management service. This occurs when a patient develops a symptom unrelated to the surgery. Some non-Medicare payers will allow modifier 24 on an E/M service when it is for a complication related to the surgery; check your payer guidelines.

**Example**

S: The pt. is a 38 y.o. G3P3 female s/p TAH for fibroids and menorrhagia 2 weeks ago. 1 nl p.o. visit last week. She now complains of a left breast lump. 2 She has done well postoperatively, minimal bleeding, moderate pain requiring pain medication 2-3 times/day. 3 She noted the breast lump a few days ago. 4 No previous history. It is mildly tender. 5 It is the size of a “small marble” and is below the nipple. 6 She has not noted any nipple discharge. 7 She had 3 SVDs, breast fed all three daughters for about 3 months each, youngest daughter is 4 years old. She takes no other meds than pain meds for the hysterectomy. 8 She denies any family history of breast Ca. 9 She had a screening mammogram at age 35, nl. 10

O: VS—BP 124/74, P 68, T 98.6, RR 20. 11 Breasts—equal size, normal appearance, no dimpling. No visible nipple discharge.
Right—without masses, non-tender, 13 no lesions 14
Left—1.5 X 2cm mobile, smooth mass, 2cm inferior to nipple, 1+/4+ tender to palpation, No discharge, no retraction of nipple 15
Abdomen—incisions dry, intact, minimal bruising, steri-strips off 16
Legs—negative, non-tender 17

A: (1) 1.5 X 2cm breast lump 18 (2) nl p.o. course s/p LAVH
P: mammogram asap 19 RTC for p.o. check-up in 4 weeks per previous plan; refill of pain meds PRN

After removing the documentation related to the TAH postoperative visit, the history is expanded problem focused, exam is problem focused, and MDM is moderate. This is an office visit for an established patient which requires 2 of the 3 key components be met. The level of E/M is 99213.

1 TAH is an abbreviation for Total Abdominal Hysterectomy which has a 90 day global period. The TAH is documented as 2 weeks ago, indicating we are still within the global period.
2 New problem unrelated to the TAH surgery.
3 Part of the postoperative documentation, not included in the level of the E/M.
4 HPI: Location
5 HPI: Duration
6 HPI: Severity
7 HPI: Location
8 ROS: Integumentary
9 PFSH: Past Medical
10 PFSH: Family History
11 ROS: Integumentary
12 Part of the postoperative documentation, not included in the level of the E/M.
13 Integumentary: Palpation of skin and subcutaneous tissue
14 Integumentary: Examination of skin an subcutaneous tissue
15 Integumentary: Palpation of skin and subcutaneous tissue
16 Part of the postoperative documentation, not included in the level of the E/M.
17 Part of the postoperative documentation, not included in the level of the E/M.
18 New problem with uncertain prognosis.
19 Mammogram ordered

Modifier 25
Modifier 25 is used to indicate a procedure or service is separately identifiable from the E/M service. Both services are required to be performed by the same physician for Modifier 25 to apply. The medically necessary visit can be performed along with a preventive visit (eg, initial preventive physical examination), a procedure (eg, lesion removal), or a service (nebulizer treatment) requiring Modifier 25.

When a medically necessary E/M service is provided in the same session as an initial preventive physical examination (IPPE) or an annual wellness visit (AWV), Modifier 25 is appended to the medically necessary E/M visit to identify it is separately identifiable from the preventive visit.

When a procedure is performed, there is a certain amount of evaluation and management work inherent to the procedure. When determining the value of a procedure, carriers take into consideration the pre-service, intra-service, and post-service work typically associated with that procedure. For example, according to AMA’s CPT® Reference of Clinical Examples, pre-service work for an aspiration of a cyst includes, “Communicate with other professionals. The treatment options and radiographs are reviewed. The procedure, including discussion of possible complications,
is reviewed with the patient. Patient consent is obtained, and communication is conducted with the patient’s family.” The post-service work includes, “The injection area is cleansed, and a compression bandage is applied. The patient is monitored for any potential complications from the injection. The patient and/or caregiver are instructed on appropriate activities and home care, and future management of the condition is discussed. The medical record is completed.”

This is further supported by the National Correct Coding Initiative (NCCI) instructions. NCCI states, “Since minor surgical procedures and XXX procedures include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider should not report an E&M service for this work. Furthermore, Medicare Global Surgery rules prevent the reporting of a separate E&M service for the work associated with the decision to perform a minor surgical procedure whether the patient is a new or established patient.“

To report an E/M code in addition to the procedure, the E/M services performed would have to be above and beyond the typical work involved in the procedure, and significant enough to report an additional E/M code.

In making the determination of whether to bill for an E/M code in addition to a preventive visit, service, or procedure, review the documentation. Can the documentation be split apart and still support both services?

**Example**

**Established Patient Office Visit**

**Chief Complaints/Concerns:**

1. **head congestion**
   - **Onset:** 1 Week(s) ago
   - **It occurs daily**
   - **The problem is acute**
   - **She is also experiencing:** ear pain, rhinorrhea
   - **Additional information:** Lt side jaw pain, goes into ears
   - **Last week felt like she had water in the ear, ear ache for 1 wk and the congestion for the past 2-3 days**

2. **boil**
   - **large nasty looking boil under left arm, very painful**

**Review of Systems**

- **Constitutional:** Negative for fever
- **HEENT:** Comments: Feels her glands have been swollen for months
- **Respiratory:** No cough, no audible wheeze, respirations normal
- **Dermatologic:** Still getting a rash which she thinks that she is getting from work. Clears over the weekend but then returns as soon as back to work.

**Physical exam**

- **Vital Signs:** Temp F 98.1, BP 110/80, Weight Lb 123
- **General/Constitutional:** No apparent distress. Well nourished and well developed
- **Ears:** Hearing grossly intact. Tympanic membranes normal
- **Nose/Throat:** Mucous membranes normal. Oropharynx appears normal. No mucosal lesions
- **Neck/Thyroid:** No cervical adenopathy
- **Respiratory:** Normal to inspection, Lungs clear to auscultation
- **Cardiovascular:** Regular rhythm. No murmurs, gallops or rubs

**Integumentary:** Visual lesion(s) appears as abscess on the axilla, left, red in color. Shape is round. Arrangement is isolated, and has a poorly demarcated distribution. Status is worse.

**Comments:** Some surrounding erythema into the upper arm as well.

**Procedures:**

**Incision and Drainage**

A written consent was obtained from the patient. The abscess was prepped and draped using sterile technique. No packing was used. A simple or single incision and drainage of an abscess was performed. A sterile dressing was applied. After care and wound instructions were given.

**Additional Physician Comments:** Pt not very tolerant of procedure but wouldn’t have been tolerant of injection for lidocaine so proceeded without this. Fair amount of purulent, bloody d/c obtained.
Assessment/Plan

Boil, axilla, acute. Incision performed and will place on Keflex and do warm compresses.

Acute sinusitis. Acute. Probable viral infection so supportive measures.

Medications ordered this visit:

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Dose</th>
<th>Sig Desc</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keflex</td>
<td>500mg</td>
<td></td>
<td>02/01/2007</td>
</tr>
</tbody>
</table>

Take one by mouth three times per day

In this example, all of the documentation related to the incision and drainage is in blue. The remaining documentation (black) supports an expanded problem focused history, detailed exam, and a straightforward MDM. For an established patient office visit, 2 of 3 key components are required. The documentation supports 99213.

The codes reported for this service would be 99213-25, 10060.

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**Modifier 32**

Modifier 32 is used to show a service was mandated by a third party payer (e.g., Workers’ Compensation) or government, or that the service is a legislative or regulatory requirement. Examples include drug testing mandated by the court, or a workers’ compensation carrier requesting a second opinion on a work-related injury. Modifier 32 does not affect Medicare payment.

**Modifier 57**

Modifier 57 is used when the decision for surgery is made during an E/M service on the day of, or the day before a surgery. This is not to be confused with modifier 25. When determining whether to use modifier 25 or 57, look at the procedure performed. If the procedure is a minor procedure (0 or 10 global days), use modifier 25 on the separately identifiable E/M visit. If the procedure is a major procedure (90 global days), use modifier 57 on the separately identifiable E/M visit. Payers will have different guidelines for the use of modifier 57; check your payer policies.

**Example**

**Subsequent Hospital Visit—Progress Note**

I had the opportunity to meet with Mr. and his family today in regard to his unusual clinical and radiographic abnormalities. Briefly, he is a very pleasant, 78-year-old man who is in fairly good health who eight weeks ago had increasing back pain. His back pain has been getting progressively worse, particularly when he stands for a long time and is associated with lower extremity symptoms consisting of bilateral numbness and tingling for about two weeks. In addition, he does report balancing difficulties. Otherwise he is doing well. Per history he has no coagulopathy. He has no contacts. He has had no significant foreign travel except to Mexico and was initially seen in my clinic because of a radiographic abnormality and was then admitted to the hospital.
In the last two days he had MRI scans of the cervical, thoracic, and lumbar spine, which showed a large cystic mass extending from the upper thoracic spine all the way to the sacrum. An MRI scan of the head demonstrated no significant abnormalities. Because this lesion was likely to be felt to be intradural, a CT myelogram was obtained yesterday both immediately and with delayed contrast images. These did demonstrate that this cystic structure does not fill with contrast and caused significant spinal cord compression, in particular at the T12-L1 area. The cyst extends all the way to approximately the T2-3 level and at that point it tapers out. Because there is no contrast on the delayed images the structure does not appear to communicate with the CFS space. There is no significant remodeling of the bony structures adjacent to it. Of note, on the contrast-enhanced MRI scans that this fracture did have peripheral enhancement, which was diffuse.  

Of significance, on laboratory workup the patient’s white count was 4, his sedimentation rate was low and his CRP was 0.2. Yesterday a CSF sample was submitted, which demonstrated that the CSF was clear and colorless with normal opening pressure with a cell count of 51 WBC and 3 RBCs. Protein, glucose, and other values were within normal limits.

PHYSICAL EXAMINATION

On examination, the patient does have significant posterior column dysfunction consistent with decreased vibratory sense, discrimination sense and difficulties with walking.  

RADIOGRAPHIC STUDIES: See above.

ASSESSMENT AND PLAN

I discussed these findings with Mr. and with his wife and his sons in detail. I spent 45 minutes going over the exam findings, the imaging findings, and the uncertainty of that diagnosis with him. Prior to meeting with him I did go over the studies with the neuroradiology team who felt that the exact nature of this lesion is uncertain at this point. Given that this is likely a cystic structure, I do think that surgical exploration is indicated because the patient does have symptoms from it. I discussed with him the risks and benefits of both a lumbar laminectomy and a thoracic laminectomy. These include spinal cord injury, spinal fluid leakage, and depending on the nature of the lesion, if it is an arachnoid cyst, certainly there could be increasing hydrocephalus, spinal cord damage, and also infection associated with that.

Given all the pros and cons and the nature of the lesion, the patient has agreed to proceed initially with a lumbar laminectomy, fenestration of the cyst, and possibly a second thoracic laminectomy with fenestration of the cyst at the cranial end. Given the current imaging findings, this could also be either an epidural lesion or a subdural blood clot, which would change the treatment paradigms. He is aware of the pros and cons of the exploratory nature and we also offered to follow him in clinic with careful observation; however, he felt that he needs a more certain answer as to what the etiology is and has agreed to proceed with surgery, which I have scheduled for today.
Some additional modifiers to be familiar with when coding tests and procedures performed in conjunction with E/M services include:

**Modifier 26 & TC**
Certain procedures are a combination of a professional component (26) and a technical component (TC). When the professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number. The professional component reports the interpretation and report of the test. Modifier TC reports the technical component and is reported by the provider who owns the equipment.

**Modifier 22**
Increased Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure code number. Documentation must support the substantial additional work and the reason for the additional work.

**Modifier 51**
Multiple Procedures: When multiple procedures, other than E/M services are performed at the same session by the same provider.

**Modifier 52**
Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician’s discretion. Under these circumstances the service provided can be identified by its usual procedure code and the addition of modifier 52.

**Modifier 58**
Staged or Related Procedure or Service by the Same Physician During the Postoperative Period: It may be necessary to indicate that the performance of a procedure or service during the postoperative period was:

a) planned prospectively at the time of the original procedure (staged);

b) more extensive than the original procedure; or

c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier 58 to the staged or related procedure.

**Modifier 59**
Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify services not normally reported together, but is appropriate under the reported circumstances. CMS NCCI documentation has specific examples for the correct use of modifier 59.

Refer to Appendix A of your CPT® codebook for a complete list of modifiers and descriptions available.