

Proper Use of Modifiers –25, –59 and –50

Modifiers are two-digit codes appended to procedure codes and/or HCPCS codes to provide additional information about the billed procedure. In some cases, addition of a modifier may directly affect payment. Below is a list of the most frequently used modifiers including the modifier description and instructions for proper use.

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 pre-operative and post-operative care associated with the procedure or service performed.
- Bill modifier 25 with the appropriate level of E/M service.
- Bill modifiers 24 and 25 when a significant, separately identifiable E/M service on the day of a procedure falls within the post-operative period of another unrelated, procedure.

59: Distinct procedural service

- Modifier 59 indicates a procedure or service was distinct or separate from other services performed on the same day.
- Represented by a different session or patient encounter, different procedure or surgery, different site, separate session, or separate injury (or area of injury)
- Modifier 59 indicates the secondary, additional, or lesser procedure.
- Modifier 59 is not valid on E/M codes.
- Use modifier 59 if no other valid modifier exists. CMS established modifiers indicating services provided on the same date to different anatomic sites (i.e., for eyelids, E1 through E4; for fingers FA, and F1 through F9; for toes, TA, and T1 through T9; LT and RT).

50: Bilateral procedure

- Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day.
- Check the MPSFDB to be sure the surgical code is billable as bilateral by checking the "Bilt Surg" column on the database.
- The following MPFSDB indicators show 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).
- The CPT book specifies that a service could be a. unilateral, b. bilateral, or c. unilateral or bilateral. This modifier is not appropriate on codes where the CPT specifies b or c.