Surgical Modifiers

A Surgical Team: Modifiers -54, -55, And -56

The default assumption in medical coding is that one physician does all the work on a patient case when a procedure is performed. Frequently, however, more than one highly trained professional is involved in the patient’s care. These modifiers help the coder specify the various ways health care professionals collaborate.

Modifiers -54, -55 and -56 describe a team of professionals taking different roles. Most surgical codes are paid on the Global Surgical Package concept. This means that preoperative visits, intraoperative services, complications following surgery, post-operative visits, supplies and miscellaneous services are included in the payment with one surgical code. If the procedure is a coronary artery bypass 33510, and three doctors work on the case, the doctor who performed the surgery is indicated by the -54 code. If another physician or nurse provided preoperative evaluation, it is shown with a -56; if postoperative care, -55. Medicare does not recognize modifier -56.

**Example**

- 33510 Coronary artery bypass, vein only; single coronary venous graft
- 33510-54 Coronary artery bypass, vein only; single coronary venous graft, Surgery only
- 33510-56 Coronary artery bypass, vein only; single coronary venous graft, preoperative evaluation only
- 33510-55 Coronary artery bypass, vein only; single coronary venous graft, postoperative care only
Deciding On Surgery: Modifiers -57 And -58

Modifier -57, Decision for Surgery, is appended to an E/M code to indicate that the person performing the evaluation/management procedure decided to schedule surgery for that procedure. Modifier -57 can be used with E/M codes or with ophthalmologic codes (92002-92014) in the Medicine section of the CPT tabular. Do not add the -57 modifier to surgery codes.

Some third-party payers will pay a physician separately from the surgical package for the initial evaluation of a condition that requires surgery.

Modifier -58 notifies an insurer that a health care provider or providers planned or staged a subsequent surgery at the time of the first surgery. It requests full payment for a subsequent procedure that may have been planned at the time of the first surgery, during a follow-up appointment. A new global period begins with each subsequent procedure modified with -58.

Distinct Procedural Service Modifier -59

Modifier -59 is used to claim payment for individual services that are usually bundled together. The parts of the procedure are usually covered by one code, even if they are performed at a different session or as part of a different procedure or surgery.

This is a modifier that providers have abused in the past, and third-party payers consider submitted excessively.

Two Surgeons: Modifiers -66, -80 and -82

There are several codes to tell an insurer the role of several surgeons on a single procedure.

Modifier -62 indicates two physicians of different specialties worked together as co-surgeons, and each surgeon dictated his or her own report.
Modifier -66 is used for surgeries that require more than two physicians, again of different specialties.

Modifier -80 indicates the services of an assistant surgeon.

Modifier -81 indicates an assistant surgeon who provides services that are less extensive.

Modifier -82, Assistant Surgeon (When Qualified Resident Surgeon Not Available), is only used when the hospital has an affiliation with a medical school and has a residency program. Hospital residence programs provide surgical assistants; this code indicates when another physician takes the assistant role.

Repeat Procedures and the Postoperative Period

Modifiers -76 through -79 describe repeat procedures. Modifier 76 is a Repeat Procedure or Service by Same Physician or Other Qualified Healthcare Professional. It is used to show the third-party payer that a repeated service isn't a duplicate and that it isn't being charged by accident. Without modifier -76, insurers would not reimburse a physician repeating the same procedure.

Modifier -77 is used for a repeat procedure with a second physician. If the second practitioner only repeats part of the original procedure, the coder also uses the -52 modifier for Reduced Services.