



# Appropriate guidelines for CPT modifiers 2025

## Modifiers 22, 25, 93 and 95

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**Sources:**

- [CPT® Appendix T and Modifier 93: Audio-only medical services](#). American Medical Association (AMA).
  - [Medicare List of Telehealth Services](#). Centers for Medicare and Medicaid Services.
  - [Medicare Learning Network Telehealth and Remote Patient Monitoring Booklet](#). Centers for Medicare and Medicaid Services. April 2025.
  - [Mental health visits via telecommunication for rural health clinics and Federally Qualified Health Centers: MLN Matters article SE22001](#). Centers for Medicare & Medicaid Services. May 23, 2023.
  - [Medicare Claims Processing Manual, Chapter 12: Physicians/Nonphysicians Practitioners](#). Centers for Medicare & Medicaid Services. Dec. 19, 2024..
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The use of modifiers is an important part of coding and billing for health care services. The reporting physician appends a modifier to a CPT® code to indicate special circumstances that affect the service provided without affecting the service or procedure description itself. When applicable, the appropriate 2-character modifier should be used to identify the modifying circumstance. The modifier should be placed after the procedure or service code number. There are limitations for the reporting of certain modifiers with specific codes, and placement of a modifier after a CPT code does not ensure reimbursement.

### Modifier 22

Modifier 22 indicates that a procedure or service performed required significantly greater effort and work than what would usually be involved. This modifier may be reported with any code from the anesthesia, surgery, radiology, pathology/laboratory and medicine sections of the CPT code book.

#### Modifier 22 increased procedural services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (such as increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).  
Note: This modifier should not be appended to an evaluation and management (E/M) service.

Modifier 22 should be appended to the procedure or service code that warranted the increased effort and should typically be submitted with a narrative detailing the specific increased work and complexity that necessitated the use of this modifier.

#### Appropriate use of modifier 22

- Modifier 22 is appended to the basic CPT procedure code when the service(s) provided is greater than usually required for the listed procedure. Use of modifier 22 allows the claim to be considered individually.
- Modifier 22 identifies an increment of work that is infrequently encountered with a particular procedure and is not described by another code.

- When using modifier 22, a concise statement regarding the increased service and use of modifier 22 must be supported in the operative report. For providers submitting paper claims, a brief, concise cover letter may be attached to the claim that clearly indicates the additional work and use of modifier 22. For electronic claims, this information may be included in the narrative field. Additional report or concise statement must clearly explain difficulty and the reason for the increased amount of work above the normal requirement.

Documentation includes, but is not limited to, descriptive statements identifying the unusual circumstances and operative reports (state the usual time for performing the procedure and the prolonged time due to complication, if appropriate). Language that indicates unusual circumstances would be: describing the difficulty of the procedure, increased risk, hemorrhage, excess blood loss, significant trauma complicating the procedure, etc. A slight extension of the procedure or the performance of a routine part of a procedure, such as routine lysis of adhesions, do not validate the use of the modifier 22.

**Examples of unacceptable statements include:**

- The surgery was difficult, harder or longer than normal
- Surgery was performed on a morbidly obese patient
- Surgery took an extra 2 hours

- Surgical procedures that require additional physician work due to medical emergencies may warrant the use of modifier 22 after the surgical procedure code.
- Modifier 22 is applied to any code of a multiple procedure claim, whether that code is the primary or secondary procedure. In these instances, the Medicare contractor first applies the multiple surgery reduction rules (for example, 100%, 50%, 50%, 50%, 50%). Then, a decision is made as to whether modifier 22 should be paid. For example, if the fee schedule amounts for procedures A, B and C are \$1,000, \$500 and \$250, respectively, and modifier 22 is submitted with procedure B, the contractor would apply the multiple surgery payment reduction rule first (major procedure 100% of the Medicare fee schedule) and reduce the procedure B (second surgical procedure) fee schedule amount from \$500 to \$250. The contractor would then decide whether to pay an additional amount above the \$250 based on the documentation submitted with the claim for increased procedural services, as designated by modifier 22.
- CPT codes for use with modifier 22 are 00100–01999, 10004–69990, 70010–79999, 80047–89398, 90281–99199 and 99500–99607, unless limited by the payer.

**Inappropriate use of modifier 22**

- Appending modifier 22 to a surgery code without documentation in the medical record of an increased procedural service. Because of the modifier's overuse, many payers do not acknowledge it.
- Appending modifier 22 to a surgery code when another CPT code captures the provided service.
- Reporting increased E/M service time, skill or service with modifier 22.
- Using modifier 22 with facility coding – modifier 22 is a physician-only modifier.

**Medicare guidance**

- Using modifier 22 identifies the service as one requiring individual consideration and manual review.
- Overuse of modifier 22 could trigger a payer audit, so make sure that modifier 22 is used only when sufficient documentation is present in the medical record.
- A Medicare claim submitted with modifier 22 is forwarded to the contractor medical review staff for review and pricing. With sufficient documentation of medical necessity, increased payment may result.

- Do not inundate Medicare contractors or other third-party payers with unnecessary documentation. All attachments to the claim for justification of the increased procedural services should explain the special circumstances in a concise, clear manner. This information should be easy to locate within the attached documentation. Highlight this information, if necessary, to facilitate the medical reviewer's access to the pertinent supporting data.
- Modifier 22 may be used on procedure codes with a Medicare global period of zero days, 10 days or 90 days when increased procedural circumstances warrant consideration of payment in excess of the fee schedule allowance.
- A claim with modifier 22 will be processed on a by-report basis and will delay the claim adjudication process. In these cases, Medicare will consider the nature of the service and, if it believes a charge above the fee schedule is justified, will approve an amount that recognizes the increased services. This, in effect, becomes a higher-than-usual fee schedule amount for the service. The approved amount (or higher fee schedule amount) is the basis of the limiting charge calculation for modifier 22 services. Therefore, if the billed amount exceeds Medicare's approved amount by more than 15%, adjust the bill or refund money to the patient to meet the limiting charge requirements. Because the exact limiting charge on these cases is not known until an allowable amount decision is made, Medicare would not consider these cases as knowing or willful violations, provided the physician made the appropriate adjustments or refunds.

## Modifier 25

Modifier 25 is used to identify a significant, separately identifiable evaluation and management (E/M) service by the same physician or other qualified health care professional on the same day of the procedure or other service that is over and above the normal standard of care associated with the procedure or service.

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

### Appropriate use of modifier 25

- To indicate that on the day of a procedure or other service identified by a CPT code, the patient's condition required a significant, separately identifiable E/M service above and beyond that associated with another procedure or service being reported by the same physician or other qualified health care professional (QHP) on the same date, or beyond the standard of preoperative and postoperative care associated with the procedure that was performed.
- On preoperative critical care codes billed within a global surgery period to indicate that they represent services beyond the usual standard of care.
- When billing for an E/M service performed at the same session as a preventive care visit when an E/M service representing additional work is performed with a preventive care service.
- Assign to any E/M code representing a significant, separately identifiable service performed on the same day as a medically necessary, routine foot care visit.
- The service must be supported by documentation in the medical record that meets relevant criteria required for the E/M service to be reported.
- Do not append to non-E/M services.

- Should not be appended to an E/M service performed on a different day than the procedure, even if the decision to perform the procedure was made during the E/M service.
- Do not report an E/M level of service code with modifier 25 on the same day as a minor procedure when the patient's visit to the office was explicitly for the minor procedure.
- Medicare will allow separate payment for 2 office visits provided on the same date, by the same physician, when each visit is rendered for an unrelated problem. Both visits must occur at different times of the day and both visits must be medically necessary. This circumstance is considered rare and requires modifier 25 to be added to the second visit.
- Although the CPT code book does not limit this modifier to use only with a specific type of procedure or service, the general rule most insurance payers follow is that they will pay for an E/M visit and a minor procedure on the same day. Keep in mind, third-party payers may follow the CPT code book, Medicare's guidance or their own definition of a minor procedure.
- There is a difference between the CPT code book definition and the instructions from Medicare regarding the appropriate reporting of modifier 25 in conjunction with a surgical procedure or service. Medicare guidelines instruct coders to use modifier 25 if the decision for surgery is made on the same day as a minor surgery (such as in those with a zero-day to 10-day follow-up period) or diagnostic procedure. Modifier 57 would be added to the appropriate level of E/M code when the initial decision to perform major surgery (for example, those with a 90-day follow-up period) is made during an E/M service the day before or the day of surgery.
- E/M service may be prompted by the sign or symptom for which the procedure/service was provided. Therefore, different diagnoses are not necessary for reporting the E/M service on the same date.
- For a trivial or insignificant issue encountered during a preventive medicine service that does not require significant additional work, a separate office or other outpatient visit code should not be reported.

#### **The 2 scenarios where modifier 25 is typically used:**

1. Preventive medicine provided along with a problem-oriented office/outpatient E/M service. For instance, during a well-child visit, a health issue like otitis media is identified which requires additional work to perform key components of an E/M service. In this case, both the preventive medicine E/M service and the problem-oriented E/M code should be reported with modifier 25, allowing separate payment for these services.
2. Minor surgical procedure provided along with a problem-oriented office/outpatient E/M service. If a minor surgical procedure involves additional work beyond the preoperative evaluation, a separate E/M service can be reported using modifier 25. For example, a patient presents with a head laceration and a neurological examination is performed before repairing the head laceration. The additional work involved in the neurological examination may be reported with a separate E/M service and modifier 25.

Another way to determine whether an E/M service justifies use of modifier 25, per CPT guidelines, is to consider the following questions:

- Did the physician perform and document the level of medical decision-making or total time necessary to report a problem-oriented office/outpatient E/M service?
- Could the work addressing the issue stand alone as a reportable service?
- Did the physician undertake extra work above and beyond the standard preoperative or postoperative care associated with the procedure?

If the answer to these questions is "yes," the use of modifier 25 is consistent with CPT guidelines.

## Coding example

An established patient presents for a hysteroscopy with endometrial biopsy due to uterine bleeding. The patient is also evaluated for a breast cyst. The breast evaluation consists of a medically appropriate history and physical exam and medical decision-making of low complexity.

In this example, only the E/M elements of the visit related to the breast cyst would be used to justify the correct level of service for the office visit. Submit the appropriate level of established office visit (99212-99215) with modifier 25 and 58558.

## Modifiers 93 and 95 for telehealth services

Two CPT modifiers for use with telehealth services are modifiers 93 and 95. Modifier 93 represents audio-only services, while modifier 95 represents audio-video telemedicine services. CPT codes that may be used for these services can be found in appendixes P and T in the CPT code book.

### Modifier 93

Modifier 93 indicates telemedicine service. These are certain, designated services most frequently reported in a traditional face-to-face setting but that are also reportable when performed in a telemedicine setting, where the patient is located off-site from the location of the provider using synchronous or “real-time” interactive audio-only communications systems. This modifier should be used only for services with a corresponding code listed in appendix T of the CPT code book.

**Modifier 93: Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System.** Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

### Appropriate use of modifier 93

- Modifier 93 is reported with codes identified by a speaker icon as being a telemedicine service (listed in appendix T of the CPT code book).
- When reporting modifier 93 with a code from appendix T, ensure all criteria have been met:
  - The nature and amount of interaction and information exchanged between provider and patient are commensurate with the key components or requirements specified had the service been rendered face-to-face.
  - A real-time interactive audio telecommunications system is used.
  - The provider and patient are in different locations when the service is provided.
  - The service has been identified as a telemedicine service by the use of a speaker icon and is listed in appendix T of the current CPT code book.

### Medicare guidance

Per Medicare Learning Network (MLN) Matters SE22001, CPT modifier 93 or HCPCS modifier FQ must be used by Rural Health Clinics (RHCs) or Federally Qualified Health Centers (FQHCs) when reporting eligible mental health services provided using audio-only technology. Providers may choose one or both “FQ” and “93” modifiers where appropriate and accurate, as they have the same meaning.

## Modifier 95

Modifier 95 indicates telemedicine services. These are certain, designated services most frequently reported in a traditional face-to-face setting but that are also reportable when performed in a telemedicine setting, where the patient is located off-site from the location of the provider using synchronous or “real-time” interactive audio and video communications systems. This modifier should be used only for services with a corresponding code listed in appendix P of the CPT code book.

**Modifier 95: Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System.** Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Modifier 95 may only be appended to the services listed in appendix P – the list of CPT codes for services that are typically performed face-to-face but may be rendered via a real-time (synchronous) interactive audio and video telecommunications system.

### Appropriate use of modifier 95

- Modifier 95 is reported with codes identified by a star icon as being a telemedicine service (listed in appendix P of the CPT code book).
- When reporting modifier 95 with a code from appendix P, ensure all criteria have been met:
  - A real-time interactive audio-visual telecommunications system is used.
  - The nature and amount of interaction and information are commensurate with the key components or requirements specified had the service been rendered face-to-face.
  - The provider and patient are in different locations when the service is provided.
  - The service has been identified as a telemedicine service by the use of a star icon and is listed in appendix P of the current CPT code book.

### Medicare guidance

Per Medicare Learning Network (MLN) Telehealth and Remote Patient Monitoring booklet dated April 2025, modifier 95 is used for outpatient therapy services provided via telehealth by a qualified physical/occupational therapist or speech language pathologist who is employed by a hospital. For professional billing, use POS indicator 02-Telehealth to indicate the service was provided in an originating site other than the patient’s home, or POS 10-Telehealth for services when the service is provided when the patient is in their home.

Effective January 1, 2025, new telemedicine CPT codes 98000-98016 were added to the CPT code book. Codes 98000–98007 represent synchronous audio-video E/M services and 98008–98015 represent synchronous audio-only E/M services. Code 98016 represents a brief synchronous communication technology service such as a virtual check-in that is initiated by an established patient.

Per the CMS CY 2025 Physician Fee Schedule, there was no programmatic need to recognize new codes 98000–98015 for payment under Medicare. Refer to office and other outpatient E/M codes (99202–99215) and other services currently on the Medicare telehealth list to report audio-video and audio-only telecommunication services furnished via synchronous 2-way communication technology for Medicare patients. Use the appropriate place of service (POS) code on the claim to identify the location of the patient and, when appropriate, append telemedicine modifier 93 or FQ to identify services furnished via audio-only services. Although CMS has chosen not to recognize most of the new telemedicine codes, they will recognize code 98016 for reimbursement.

Originating sites, those sites where the telehealth service is being provided to the patient, are paid an originating site facility fee for telehealth services. HCPCS Level II code Q3014 Telehealth originating site facility fee, describes this fee and should be submitted to the Medicare Administrative Contractor (MAC) as a separately billable Part B payment.

Medicare and commercial payers should be contacted regarding their coverage guidelines and coding guidance for telehealth services.

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