
Modifier Reference Guide

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General Instructions

A service or procedure can be further described by using 2-digit modifiers. The Modifier Reference Guide lists Level I (CPT-4), Level II (non-CPT-4 alpha numeric), and Level III (local) modifiers. Level I and II modifier definitions are contained in the Healthcare Common Procedure Coding System (HCPCS). Level III modifiers are defined by the Fiscal Intermediary and may be added only with prior Centers for Medicare & Medicaid Services (CMS) approval. Modifiers can be used interchangeably with any code level.

Ranking Modifiers

The Medicare claim form contains two modifier fields (item 24d).

When entering only one modifier, enter it in the first modifier field.

When entering a pricing modifier, enter it in the first modifier field only. As an example, when billing for the professional component (26) or the technical component (TC) enter the 26 or the TC modifier in the first modifier field.

When entering a pricing modifier and a statistical modifier that affects pricing; enter the pricing modifier in the first modifier field and the statistical modifier that affects pricing in the second modifier field. As an example, when billing for the professional component (modifier 26) in a Health Professional Shortage Area (HPSA) (modifier QB) enter 26 in the first modifier field and QB in the second modifier field.

When entering a statistical modifier that affects pricing and a statistical/informational modifier, enter the statistical modifier in the first field and the statistical/informational modifier in the second field. As an example, when billing for the professional component (modifier 26) and repeated procedure by the same physician (modifier 76) enter 26 in the first modifier field and the 76 in the second modifier field.

When entering more than one statistical/informational modifier with no modifiers that affect pricing, it does not matter which modifier is entered first. The exception is for the QT, QW and SF modifiers. These three modifiers are valid in the first modifier field only.

When more than four modifiers apply, enter modifier 99 in the first modifier field. In the narrative field (item 19 on the claim form) list all modifiers in the correct ranking order being sure to identify which detail line or procedure code to which the modifiers apply.

Modifier Categories

When more than one modifier is submitted, the modifiers must be ranked. The following categories serve as a reference point when ranking modifiers.

- A. **Pricing Modifiers** are considered part of the seven-digit procedure code by the CMS and are used to determine the reasonable charge or fee for a service.

*TC

*26

- B.

* Denotes modifiers which are valid for the first modifier field only.

- C. **Statistical Modifiers that Affect Pricing** are appended to a procedure code and always cause the reasonable charge or fee for the code billed to be modified in the same way every time.

*AA	*AD	AH	AJ	AS	GM
QB	*QK	QU	*QX	*QY	QZ
SG	*UN	*UP	*UQ	*UR	*US
21	22	50	51	52	53
54	55	56	62	66	73
74	78	80	82	99	

D.

* Denotes modifiers which are valid for the first modifier field only.

E. **Statistical / Informational Modifiers** are used for documentation purposes and can affect the processing or payment of the code billed.

AT	AM	CC	E1	E2	E3	E4	EJ	EM	EP	ET
F1	F2	F3	F4	F5	F6	F7	F8	F9	FA	FP
G1	G2	G3	G4	G5	G6	G7	G8	G9	GA	GB
GC	GE	GG	GH	GJ	GN	GO	GP	GQ	GT	GV
GW	GY	GZ	KO	KP	KQ	LC	LD	LR	LS	LT
Q3	Q4	Q5	Q6	Q7	Q8	Q9	QA	QC	QD	QL
QM	QN	QP	QQ	QS	*QT	QV	*QW	RC	RP	RT
*SF	T1	T2	T3	T4	T5	T6	T7	T8	T9	TA
VP	23	24	25	32	47	57	58	59	76	77
79	*90	91								

F.

* Denotes modifiers which are valid for the first modifier field only.

Level I - CPT-4 Modifiers

- 21- Prolonged E & M Services:** When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management (E&M) service within a given category.
- 22- Unusual Procedural Services:** When the service(s) provided is greater than that usually required for the listed procedure. **Note:** This modifier is not to be used to report procedure(s) complicated by adhesion formation, scarring, and/or alteration of normal landmarks due to late effects of prior surgery, irradiation, infection, very low weight

(neonates and infants less than 10 kg.) or trauma.

- 23- **Unusual Anesthesia:** Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances, must be done under general anesthesia.
- 24- **Unrelated E&M Service, Same Physician, During Postoperative Period:** The physician may need to indicate that an E&M service was performed during a postoperative period for a reason(s) unrelated to the original procedure.
- 25- **Significant, Separately Identifiable E&M Service by the Same Physician on the Same Day of the Procedure or Other Service:** The physician may need 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. The E&M Service may be prompted by the symptom or condition for which the procedure was provided. As such, different diagnoses are not required for reporting the E&M services on the same date. The circumstance may be reported by adding modifier 25 to the appropriate level of E&M service.
- *26- **Professional Component:** Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier 26 to the usual procedure number. Note: The 26 modifier should not be appended to procedure codes that represent a professional component (example: 93010).
- 32- **Mandated Services:** Services related to mandated consultation and/or related services (e.g., Peer Review Organization (PRO), 3rd party payer, governmental, legislative or regulatory requirement).
- 47- **Anesthesia by Surgeon:** Regional or general anesthesia provided by the surgeon.
- 50- **Bilateral Procedure:** Unless otherwise identified in the listings, bilateral procedures that are performed in the same operative session should be identified by adding the modifier 50 to the appropriate five digit CPT code.
- 51- **Multiple Procedures:** When multiple procedures, other than E&M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier

51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes.

- 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 number and the addition of the modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For outpatient hospital reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.
- 53- Discontinued Procedure:** Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.
- 54- Surgical Care Only:** When one physician performs a surgical procedure and another provides preoperative and/or postoperative management.
- 55- Postoperative Management Only:** When one physician performs the postoperative management and another physician has performed the surgical procedure.
- 56- Preoperative Management Only:** When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure.
- 57- Decision for Surgery:** An E&M service that resulted in the initial decision to perform the surgery.
- 58- Staged or Related Procedure or Service by the Same Physician During the Postoperative Period:** The physician may need 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); or (B) more extensive than the original procedure; or (C) for therapy following a diagnostic surgical procedure. **Note:** This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.

- 59- Distinct Procedural Service:** Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if there is not a more descriptive modifier available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.
- 62- Two Surgeons:** When two surgeons work together as primary surgeons performing distinct part(s) of a single reportable procedure, each surgeon should report his/her distinct operative work by adding the modifier 62 to the single definitive procedure code. Each surgeon should report the co-surgery once using the same procedure code. If an additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may be reported without the modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure(s) with the modifier 80 or 81 added, as appropriate.
- 66- Surgical Team:** Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of the modifier 66 to the basic procedure number used for reporting services.
- 73- Discontinued Outpatient Hospital/ASC Procedure Prior to the Administration of Anesthesia:** Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to

the administration of anesthesia. Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of the modifier 73. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.

- 74- Discontinued Outpatient Hospital/ASC Procedure After Administration of Anesthesia:** Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia or after the procedure was started. Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.
- 76- Repeat Procedure by Same Physician:** The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure.
- 77- Repeat Procedure by Another Physician:** The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure or service.
- 78- Return to the Operating Room for a Related Procedure During the Postoperative Period:** The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. (For repeat on the same day, see modifier 76.)
- 79- Unrelated Procedure or Service by the Same Physician During the Postoperative Period:** The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. (For repeat procedures on the same day, see modifier 76.)
- 80- Assistant Surgeon:** Surgical assistant services may be identified by adding the modifier 80 to the usual procedure number(s).
- 82- Assistant Surgeon (when qualified resident surgeon is not available in a teaching facility):** The unavailability of a qualified resident surgeon is a prerequisite for use of this modifier.
- *90- Reference (Outside) Laboratory:** Physicians use of this modifier

when laboratory procedures are performed by a party other than the treating or reporting physician.

- 91- Repeat Clinical Diagnostic Laboratory Test:** In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.
- 99- Multiple Modifiers:** Under certain circumstances more than four modifiers may be necessary to completely delineate a service.

* Denotes modifiers which are valid for the first modifier field only.

Level II - HCPCS Alpha-Numeric Modifiers

- *AA-** Anesthesia services performed by anesthesiologist.
- *AD-** Medical supervision by a physician, more than four concurrent anesthesia procedures.
- AH-** Clinical Psychologist (CP) Services. [Used when a medical group employs a CP and bills for the CP's service.]
- AJ-** Clinical Social Worker (CSW). [Used when a medical group employs a CSW and bills for the CSW's service.]
- AM-** Physician, team member service
- AS-** Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant at surgery.
- AT-** Acute treatment. [This modifier should be used when reporting a spinal manipulation service (codes 98940, 98941, and 98942.)]
- CC-** Procedure code changed. [This modifier is used when the submitted procedure code is changed either for administrative reasons or

because an incorrect code was filed.]

- E1-** Upper Left, Eyelid.
- E2-** Lower Left, Eyelid.
- E3-** Upper Right, Eyelid.
- E4-** Lower Right, Eyelid.
- EJ-** Subsequent claims for a defined course of therapy (example: EPO, sodium hyaluronate)
- EM-** Emergency reserve supply (for ESRD benefit only).
- EP-** Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program.
- F1-** Left Hand, Second Digit.
- F2-** Left Hand, Third Digit.
- F3-** Left Hand, Fourth Digit.
- F4-** Left Hand, Fifth Digit.
- F5-** Right Hand, Thumb.
- F6-** Right Hand, Second Digit.
- F7-** Right Hand, Third Digit.
- F8-** Right Hand, Fourth Digit.
- F9-** Right Hand, Fifth Digit.
- FA-** Left Hand, Thumb.
- FP-** Service Provided as Part of Medicaid Family Planning Program.
- G1-** Most recent urea reduction ratio (URR) reading of less Than 60.
- G2-** Most recent urea reduction ratio (URR) reading of 60 to 64.9.
- G3-** Most recent urea reduction ratio (URR) of 65 to 69.9.
- G4-** Most recent urea reduction ratio (URR) of 70 to 74.9.
- G5-** Most recent urea reduction ratio (URR) reading of 75 or greater.

- G6-** ESRD patient for whom less than six dialysis sessions have been provided in a month.
- G7-** Pregnancy resulted from rape or incest or pregnancy certified by physician as life threatening.
- G8-** Monitored Anesthesia Care (MAC) for deep complex, complicated, or markedly invasive surgical procedure.
- G9-** Monitored Anesthesia Care (MAC) for patient who has history of severe cardio- pulmonary condition.
- GA-** Waiver of Liability Statement on file. (Effective for dates of service on or after October 1, 1995, a physician or supplier should use this modifier to note that the patient has been advised of the possibility of non-coverage.)
- GB-** Claim being re-submitted for payment because it is no longer covered under a global payment demonstration.
- GC-** This service has been performed in part by a resident under the direction of a teaching physician.
- GE-** This service has been performed by a resident without the presence of a teaching physician under the primary care exception.
- GG-** Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day.
- GH-** Diagnostic mammogram converted from screening mammogram on same day.
- GJ-** "Opt Out" physician or practitioner emergency or urgent service.
- GM-** Multiple patients on one ambulance trip.
- GN-** Service delivered personally by a speech-language pathologist or under an outpatient speech-language pathology plan of care.
- GO-** Service delivered personally by an occupational therapist or under an outpatient occupational therapy plan of care.
- GP-** Service delivered personally by a physical therapist or under an outpatient physical therapy plan of care.
- GQ-** Via asynchronous telecommunications system
- GT-** Via interactive audio and video telecommunication systems.

- GV-** Attending physician not employed or paid under arrangement by the patient's hospice provider.
- GW-** Service not related to the hospice patient's terminal condition.
- GY-** Item or service statutorily excluded or does not meet the definition of any Medicare benefit.
- GZ-** Item or service expected to be denied as not reasonable and necessary.
- KO-** Single drug unit dose formulation.
- KP -** First drug of a multiple drug unit dose formulation.
- KQ-** Second or subsequent drug of a multiple drug unit dose formulation.
- LC-** Left circumflex coronary artery.
- LD-** Left anterior descending coronary artery.
- LR-** Laboratory round trip.
- LS-** FDA-monitored intraocular lens implant.
- LT-** Left Side. (Used to identify procedures performed on the left side of the body.)
- Q3-** Live kidney donor - Services associated with postoperative medical complications directly related to the donation.
- Q4-** Service for ordering/referring physician qualifies as a service exemption.
- Q5-** Service furnished by a substitute physician under a reciprocal billing arrangement.
- Q6-** Service furnished by a locum tenens physician.
- Q7-** One Class A Finding.
- Q8-** Two Class B findings.
- Q9-** One Class B and Two Class C findings.
- QA-** FDA investigational device exemption.
- QB-** Physician providing service in a rural Health Professional Shortage

Area (HPSA).

- QC-** Single channel monitoring.
- QD-** Recording and storage in solid state memory by digital recorder.
- *QK-** Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
- QL-** Patient pronounced dead after ambulance called.
- QM-** Ambulance service provided under arrangement by a provider of services.
- QN-** Ambulance service furnished directly by a provider of services.
- QP-** Documentation is on file showing that the laboratory test(s) was ordered individually or ordered as a CPT-recognized panel other than automated profile codes 80002-80019, G0058, G0059, and G0060.
- QQ-** Claim submitted with a written statement of intent.
- QS-** Monitored anesthesia care service.
- *QT-** Recording and storage on a tape by an analog tape recorder.
- QU-** Physician providing service in an urban Health Professional Shortage Area (HPSA).
- QV-** Item or service provided as routine care in a Medicare qualifying clinical trial.
- *QW-** Clinical Laboratory Improvement Amendment (CLIA) waived test (modifier used to identify waived tests).
- *QX-** CRNA service with medical direction by a physician.
- *QY-** Anesthesiologist medically directs one CRNA.
- QZ-** CRNA service without medical direction by a physician.
- RC-** Right coronary artery.
- RT-** Right Side (used to identify procedures performed on the right side of the body).
- *SF-** Second opinion ordered by a Professional Review Organization (PRO) per Section 9401, P.L. 99-272 (100% reimbursement - no Medicare

deductible or coinsurance).

- SG-** Ambulatory Surgical Center (ASC) facility service.
- T1-** Left Foot, Second Digit.
- T2-** Left Foot, Third Digit.
- T3-** Left Foot, Fourth Digit.
- T4-** Left Foot, Fifth Digit.
- T5-** Right Foot, Great Toe.
- T6-** Right Foot, Second Digit.
- T7-** Right Foot, Third Digit.
- T8-** Right Foot, Fourth Digit.
- T9-** Right Foot, Fifth Digit.
- TA-** Left Foot, Great Toe.
- *TC-** Technical Component. Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances adding modifier TC to the usual procedure number identifies the technical component charge. **Note:** The TC modifier should not be appended to procedure codes that represent the technical component (example: 93005).
- *UN-** Two patients served.
- *UP-** Three patients served.
- *UQ-** Four patients served.
- *UR-** Five patients served.
- *US-** Six patients or more served.
- VP-** Aphakic Patient.

* Denotes modifiers which are valid for the first modifier field only.

Ambulance Origin and Destination Modifiers

The modifiers listed below are used to designate the place of origin and destination of a transport. The first position identifies the place of origin and the second position identifies the destination.

Example: A patient is picked up at the scene of an accident and transported to a hospital. Place "S" (scene of accident or acute event) in the first modifier position, to indicate the place of origin. Place "H" (hospital) in the second modifier position to indicate the destination of the patient.

- D-** Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes.
- E-** Residential, Domiciliary, Custodial Facility (other than an 1819 facility).
- G-** Hospital Based Dialysis Facility (hospital or hospital related).
- H-** Hospital.
- I -** Site of Transfer (e.g., airport or helicopter pad) between modes of ambulance transport.
- J-** Non-Hospital Based Dialysis Facility.
- N-** Skilled Nursing Facility (SNF) (1819 facility).
- P-** Physician's office.
- R-** Residence.
- S-** Scene of Accident or Acute Event.
- X-** (Destination code only) Intermediate stop at physician's office on the way to the hospital.

2003 HCPCS Modifier Deletions / Additions

2003 HCPCS MODIFIER DELETIONS	
Y1-	Lab procedure sent to a reference lab, and not more than 30 percent of the clinical diagnostic tests billed annually by the referring laboratory are performed by another laboratory, which is not an ownership related laboratory
Y7-	Lab procedure sent to a reference lab, and the referring laboratory and reference laboratory are ownership related

YT-	System decision to pay lump sum
Z1-	One patient seen in a NH or SNF (R0070)
Z2-	Two patients seen in a NH or SNF (R0070)
Z3-	Three patients seen in a NH or SNF (R0070)
Z4-	Four patients seen in a NH or SNF (R0070)
Z8-	Reimburse at 100% (Adjustments Only)
ZT-	Used to identify a second clinical diagnostic laboratory service performed on the same day

2004 HCPCS Modifier Deletions / Additions

2004 HCPCS MODIFIER ADDITIONS	
UN-	Two patients served.
UP-	Three patients served.
UQ-	Four patients served.
UR-	Five patients served.
US-	Six or more patients served.

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