Modifiers are two digit or alphanumeric characters that are appended to CPT and HCPCS codes. The modifier allows the provider to indicate that a procedure was affected by special circumstances, without changing the definition of the code.

These codes can serve as informational or as a billing clarification for payment. The use of the correct modifier is an important part of avoiding fraud and abuse or non-compliance issues. Some can be easily misused and the modifier grid below should provide guidance on some of the most commonly billed modifiers.

There are two levels of modifiers: Level 1 (CPT) and Level II (CMS, also known as HCPCS).

Level I (CPT) Modifiers
Level I Modifiers are two numeric digits. The American Medical Association (AMA) updates these annually.

Level II (CMS) Modifiers
Level II Modifiers are two alphanumeric or alpha codes. They are recognized nationally and are updated annually by CMS.

Code Editing of Modifiers
Code editing software is used to apply National Correct Coding Initiative (NCCI) to edit claims for accurate usage of claims coding in compliance with CMS and general industry standards. Claims that are coded incorrectly including the misuse of modifiers are subject to denial. Please refer to the Code Auditing and Editing section of the Provider Manual for more detailed information about the correct coding edits and the impact on claims.

Documentation supporting the use of certain modifiers may be requested. Failure to provide the supporting documentation upon request will result in denials. Item 19 in the CMS 1500 or its electronic equivalent should reflect that the required documentation for a service is available.

Modifiers Chart

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Increased Procedural Services</td>
</tr>
<tr>
<td></td>
<td>This code should only be used when the work is significantly greater than typically required and included in the procedure. Documentation to support the services must be provided if requested by the payor.</td>
</tr>
<tr>
<td></td>
<td>• This code should not be appended to an Evaluation and Management Code.</td>
</tr>
<tr>
<td></td>
<td>• Example: If there were significant work involved in the delivery of a second baby for twins that is not covered within the definition of the global maternity code then modifier 22 would be appended to 59510 or 59618.</td>
</tr>
<tr>
<td></td>
<td>• The use of modifier 22 for increased procedural services should be used only in certain circumstances. Due to the chances of misuse documentation may be requested to support the use of the code. If the practitioner does not have the documentation readily available the claim is subject to denial.</td>
</tr>
</tbody>
</table>
## Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
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</table>
| 23 | **Unusual Anesthesia**  
There are times where a patient must be put under anesthesia due to a behavioral or physical concern where anesthesia is typically not used. This must be appended with a modifier 23.  
- Documentation to support the use of the modifier should accompany the claim submission.  
- Report in the 2nd modifier position. The first modifier position indicates that the anesthesia is being personally performed, medically directed, or medically supervised. (AA, AD, QY, QK, QX) See Guidelines for Anesthesia  
- Do not report with codes that are normally performed under general anesthesia |
| 24 | **Unrelated Evaluation and Management**  
If a postoperative E/M code was performed during a post operative period for reasons unrelated to the original procedure the provider should append modifier 24. This will allow the services to be considered separately outside of the global surgical package for the procedure performed. A different diagnosis should be reported and documentation provided to support if requested by the payor.  
- Used with E/M codes  
- Use on an unrelated E/M service beginning the day after the procedure when the same practitioner performs procedure during the global follow-up period.  
- Use if documentation indicates the service was for the underlying condition and not for post operative care  
- Use when the same practitioner is managing immunosuppressant therapy during the postoperative period of a transplant or chemotherapy during the postoperative period of a procedure.  
- When the same practitioner provides unrelated critical care during the postoperative period.  
DO NOT USE WHEN:  
- The E/M is for a surgical complication or injection. These are included in the global surgical fee.  
- Do not use on same day as procedure |
| 25 | **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the same Day of the Procedure and Other Service**  
- Patient’s condition must require a significant, separately identifiable E/M service  
- If two physicians belong to the same group but have different specialties and see the same patient on the same day for different conditions Modifier 25 should be used.  
*Approved for ASC use by AMA and CMS* |
<table>
<thead>
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</table>
| **26**  | Professional Component  
Appended to the professional component only of a radiology or lab code.  
• To report the practitioner's interpretation of the test of the lab or radiology service  
• Do not use when the same provider performs both the professional and technical portions of the procedure  
• Do not append to technical only procedure codes, global test codes, or professional component only codes  
• Do not report 26 and TC modifiers on the same procedure code on one line of service |
| **27**  | Multiple outpatient Hospital evaluation and management encounters on the same date.  
*Approved for ASC use by AMA and CMS* |
| **33**  | Preventive Visit  
Required to indicate the services is in accordance with the Preventative Service Task Force A or B and other ACA mandated services. Allows the payer to identify preventative services. If the deductible is to be waived this modifier can be used to alert the system to waive the deductible.  
Modifier 33 is to be used on services other than those that are inherently preventive. Example: A screening colonoscopy CPT 45378, which results in a polypectomy CPT 45388. 45378 is defined as a screening preventive procedure and therefore would not require the modifier 33 to waive cost sharing. In this situation polyps were identified during the screening and were removed resulting in a change of codes being used to reflect the screening and the removal. 45388 would have the modifier 33 appended to ensure cost share is waived.  
Please refer to the Preventive Guidelines for specific use and details of this modifier. |
| **50**  | Bilateral Procedure  
The bilateral modifier should be used only on those procedure codes not described as bilateral procedures or services. Only applicable to services or procedures performed on identical anatomical sites, aspects, organs (e.g., Arms, legs, eyes). It is entered on one line with the 50 modifier to indicate it was done bilaterally. The number of units reported should be 1. |
| **51**  | Multiple Procedures  
Multiple procedures performed by the same provider at the same session should have the modifier 51 appended to all procedures other than the primary or highest RVU procedure. The 51 triggers the multiple surgery reduction. Modifier 51 should not be appended to any 51 exempt codes listed in CPT. |
### Modifiers

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<tr>
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| **52** | **Reduced Services**<br>Reporting by a physician that the scheduled procedure was reduced or eliminated.  
- The procedure should be billed with a reduced charge to reflect that services were reduced or eliminated.  
- Do not use for terminated services  
- Do not use on time based codes such as anesthesia, critical care  
- Do not use on E/M or Consultation Codes  
- Services will be considered at 50% of base fee unless otherwise stipulated per contract.  

*Approved for ASC use by AMA and CMS* |
| **53** | **Discontinued Services**<br>Surgical procedure was stopped or discontinued due to the risk of the health of the patient.  
- The procedure was stopped after the induction of anesthesia  
- Do not use on time based codes such as anesthesia, critical care  
- Documentation must state that the procedure was started, why it was discontinued and state the percentage of the procedure performed.  

Services will be allowed at 25% of the base fee schedule unless otherwise stipulated by the contract. |
| **55** | **Postoperative Management Only**<br>When one physician performs the post operative for a surgeon who performed the surgery |
| **56** | **Physician Performed Preoperative Services Only**<br>A physician provided pre-operative care while a surgeon provided the surgery. |
| **57** | **Decision for Surgery**<br>This modifier is used with an E/M visit where the decision to perform the surgery is made either the day before or the day of the surgery. The use of the modifier allows the E/M to be paid and not included in the global surgical package. |
| **58** | **Staged or Related Procedure or Service by the Same Physician During The Postoperative Period**<br>This code indicates that this procedure is related to the primary surgical procedure and is performed during the global period. It is most often applied when the second procedure was already anticipated but could not be done at the time of the primary procedure due to the significance of the underlying disease process.  

*Approved for ASC use by AMA and CMS* |
### Distinct Procedural Service

E/M performed was distinct or separate from other non E/M services performed on that day. According to CMS Modifier 59 is used appropriately when:

- When different anatomic sites during the same encounter only when procedures, which are not ordinarily performed or encountered on the same day, are performed on different organs, or different anatomic regions or in limited situations on different non-contiguous lesions in different anatomic regions of the same organ
- When procedures are performed in different encounters on the same day
- For two services described by time codes provided during the same encounter only when they are performed sequentially
- For a diagnostic procedure, which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure
- For a diagnostic procedure which occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure

Effective January 1, 2015 modifiers XE, XS, XP, XU should be utilized in the place of modifier 59 whenever appropriate. Modifier 59 should only be used if there is no other more specific modifier available.

- XE – “Separate encounter, a service that is distinct because it occurred during a separate encounter.
- XS – “Separate Structure, A service that is distinct because it was performed on a separate organ, structure.”
- XP – “ Separate Practitioner, A service that is distinct because it was performed by a different practitioner.”
- XU – “ Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service.”


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### Two Surgeons/ Co-Surgeons

This is to be used if two surgeons are required to perform a procedure. Both surgeons must bill the same surgery code with modifier 62. Documentation of necessity must be available. The surgeons may be of different specialties.

### Discontinued Outpatient Hospital/Ambulatory Surgery Center ASC Procedure Prior to the Administration of Anesthesia

Only used if the procedure was cancelled due to a threat to the well being of the patient.

Approved for ASC use by AMA and CMS
### Modifiers

<table>
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<th>Approved for ASC use by AMA and CMS</th>
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</thead>
<tbody>
<tr>
<td>74</td>
<td>Discontinued Outpatient Hospital/Ambulatory Surgery Center ASC Procedure After the Administration of Anesthesia or After the Procedure Was Started (incision made, intubation started, scope inserted.)</td>
<td>Approved for ASC use by AMA and CMS</td>
</tr>
</tbody>
</table>
| 76       | Repeat Procedure or Service by same Physician or Other Qualified Health Care Professional  
  - Used when it is necessary to report repeat procedures performed on the same day.  
  - Report each on a separate line, using a quantity of 1 and appending 76 to each subsequent service. The first service should not have a 76 modifier.  
  - Failure to use the 76 will result in the additional procedures being denied. | Approved for ASC use by AMA and CMS |
| 77       | Repeat Procedure or Service by Another Physician or Other Qualified Health Care Professional  
  - Append to the professional component of an x-ray or EKG procedure when a different physician repeated the reading as the physician performing the initial reading believes another physician's expertise is needed.  
  - Append to the professional component of an x-ray or EKG when the patient has two or more tests and more than one physician provides the interpretation and report. | Approved for ASC use by AMA and CMS |
| 78       | Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period  
  - To treat the patient for complications resulting from the original surgery  
  - This modifier should not be used on procedures performed outside of the operating room. | Approved for ASC use by AMA and CMS |
| 79       | Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period  
  Example: Patient falls after hip surgery and breaks his elbow during the postoperative period. The fracture repair of the elbow is not related to the hip surgery therefore modifier 79 should be appended to that procedure. | Approved for ASC use by AMA and CMS |
### Modifiers

<table>
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<tr>
<th>Code</th>
<th>Description</th>
<th>Details</th>
</tr>
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<tbody>
<tr>
<td>80</td>
<td><strong>Assistant Surgeon</strong></td>
<td>This code is used when one surgeon acts as an assistant to another surgeon.</td>
</tr>
<tr>
<td>81</td>
<td><strong>Minimum Assistant Surgeon</strong></td>
<td>This code is used only when the primary surgeon indicated he needs an assistant for a very short time.</td>
</tr>
<tr>
<td>82</td>
<td><strong>Assistant Surgeon (when qualified resident surgeon not available)</strong></td>
<td>Used in teaching hospitals to show that a qualified resident assistant surgeon was not available and a non-resident surgeon assisted.</td>
</tr>
</tbody>
</table>
| 90   | **Reference (Outside) Laboratory** | This code is used when laboratory procedures are performed by anyone other than the treating or reporting physician the procedure may be identified by adding modifier 90.  
  - The outside lab cannot be related to the treating or reporting doctor. |
| 91   | **Repeat Clinical Diagnostic Laboratory Test** | If a test is repeated several times in one day to obtain subsequent results the modifier 91 may be appended.  
  - Example: same blood tests being performed several times in one day to monitor certain levels.  
  *Approved for ASC use by AMA and CMS* |
| 92   | **Alternative Laboratory Platform Testing** | A laboratory test performed using a kit or transportable instrument that consist of a single use, disposable chamber.  
  - The test does not require permanent dedicated space.  
  - The test is designed to be carried or transported to the patient for immediate testing  
  - Not acceptable for Medicare Part B. Will be rejected. |
| 99   | **Multiple Modifiers** | Indicates multiple modifiers may be necessary to completely support a service.  
  In such situations, modifier 99, should be added to the basic procedure and other applicable procedures.  
  - Report in the first modifier position  
  - All other modifiers are to go in field 19 of the CMS 1500 or 837P equivalent. |
<table>
<thead>
<tr>
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</table>
| **AA**  | Anesthesia Services Performed Personally by the Anesthesiologist  
*See Anesthesia Guidelines for further guidance.* |
| **AD**  | Medical Supervision by a Physician;  
More Than 4 Concurrent Anesthesia Procedures  
*See Anesthesia Guidelines for further guidance.* |
| **QK**  | Medical Direction of Two, Three, Four Concurrent Anesthesia Procedures  
*See Anesthesia Guidelines for further guidance.* |
| **QY**  | Medical Direction of One CRNA by an Anesthesiologist  
*See Anesthesia Guidelines for further guidance.* |
| **QX**  | CRNA Service: With Medical Direction by a Physician  
*See Anesthesia Guidelines for further guidance.* |
| **QZ**  | CRNA Service: Without Medical Direction by a Physician  
Involving Qualified Individuals |
| **XE**  | Separate Encounter, a Service That Is Distinct Because It Occurred  
During a Separate Encounter  
Effective 1/1/2015. Use in place of Modifier 59. See Modifier 59. |
| **XS**  | Separate Structure, a Service That Is Distinct Because It Was Performed  
on a Separate Organ, Structure  
Effective 1/1/2015. Use in place of Modifier 59. See Modifier 59. |
### Modifiers

<table>
<thead>
<tr>
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<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>XP*</td>
<td><strong>Separate Practitioner, a Service That Is Distinct Because It Was</strong></td>
<td>Effective 1/1/2015. Use in place of Modifier 59. See Modifier 59.</td>
</tr>
<tr>
<td></td>
<td><strong>Performed by a Different Practitioner</strong></td>
<td></td>
</tr>
<tr>
<td>XU*</td>
<td><strong>Unusual Non-Overlapping Service</strong></td>
<td>The use of a service that is distinct because it does not overlap</td>
</tr>
<tr>
<td></td>
<td><strong>The use of a service that is distinct because it does not overlap</strong></td>
<td>usual components of the main service.</td>
</tr>
<tr>
<td></td>
<td><strong>usual components of the main service.</strong></td>
<td>Effective 1/1/2015. Use in place of Modifier 59. See Modifier 59*</td>
</tr>
</tbody>
</table>

*http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/downloads/modifier.pdf*

Level II (CMS) modifiers are used to provide additional specification to a procedure being performed including but not limited to the following:

- Anatomical location a procedure is performed. (e.g. E 1 – E2 Upper left and lower left eyelid)
- Measurements (e.g. QE-prescribed amount of oxygen is less than 1 liter per minute)
- Type of provider specialty (e.g. QZ – CRNA service without medical direction of a physician)
- Type of service (e.g. QN -Ambulance Service furnished directly by a provider of service)

CMS modifiers can impact the accuracy of the payment of the claim as well as provide information about the patient or provider for data purposes. Accurate reporting of these modifiers should be used to provide the specificity to procedures performed as required. Failure to do so may result in denials or erroneous payments.