COMMUNITY Health Options®

Modifier Reference Guide

Purpose

To clarify reimbursement impact on appropriately billed modifiers as supported by nationally recognized standards and medical record documentation.

Policy

Community Health Options adheres to the billing/coding guidelines defined by American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) for appropriate use of modifiers that may be appended to HCPCS/CPT codes to provide additional information about the services rendered.

Level I CPT Modifiers: Commonly known as CPT Modifiers and consists of two numeric digits and are annually updated by AMA.

Level II HCPCS Modifiers: Commonly known as HCPCS Modifiers and consists of two digits (Alpha / Alphanumeric characters) in the sequence AA through VP. These modifiers are annually updated by CMS.

This policy contains a brief description of HCPCS/CPT Modifiers and the corresponding reimbursement impact (not an all-inclusive list):

Modifier	Description	Reimbursement Impact Notes
22	Increased Procedural Services (surgical/procedures codes only)	Community Health Options may provide additional reimbursement up to a max of 120% of the appropriate fee schedule or max allowed fee when documentation supports an increase of time and complexity compared to what is typically provided
24	Unrelated evaluation and management service by the same physician during a postoperative period (not port of global surgical package)	100% of the fee schedule or contracted/negotiated rote for the E/M service
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	100% of the fee schedule or contracted /negotiated rate
26	Professional Component Only (separate from the technical component)	100% of the fee schedule or contracted /negotiated rate
50	Bilateral Procedure Modifier 50 applies to surgical procedures (CPT codes 10040-69990) and diagnostic procedures performed bilaterally (both sides of the body).	150% of the fee schedule or contracted/negotiated rate

51	Multiple procedures	100% of the fee schedule or contracted /negotiated rate
52	Partially reduced/eliminated services	50% of the fee schedule or contracted /negotiated rate
53	Discontinued procedure (professional services only): Used only with surgical codes or medical diagnostic codes	25% of the allowable amount for the primary unmodified procedure. Multiple procedure reductions will still apply
54	Surgical care only	80% of the fee schedule or contracted /negotiated rate
55	Postoperative management only	20% of the fee schedule or contracted /negotiated rate
56	Preoperative management only	10% of the fee schedule or contracted /negotiated rate
57	An evaluation and management (E/M) service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service	100% of the fee schedule or contracted /negotiated rate
58	Staged or related procedure or service during the postoperative period by the same physician (or other qualified healthcare professional) to indicate an expected return to the operating room to complete a procedure in stages	100% of the fee schedule or contracted /negotiated rate
59	Distinct Procedural Service Modifier 59 is used only to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. It should only be used if no other modifier more appropriately describes the relationship of the two or more procedure codes.	100% of the fee schedule or contracted /negotiated rate
62	Co-Surgeons	62.5% of the fee schedule or contracted /negotiated rate
66	Team Surgeons - Surgical Team	100% of the fee schedule or contracted /negotiated rate
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure prior to the administration of anesthesia - reported to indicate that a procedure has been suspended before any local, regional or general anesthetic had been provided due to a mitigating situation in which the patient's health is potentially compromised	50% of the fee schedule or contracted /negotiated rate

74	After anesthesia administration - Discontinued Ambulatory Surgical Center (ASC) or outpatient hospital	70% of the fee schedule or contracted /negotiated rate
76	Repeat the procedure by the same physician	100% of the fee schedule or contracted /negotiated rate
77	Repeat the procedure by another physician	100% of the fee schedule or contracted /negotiated rate
78	Return to the operating room for related surgery during the postoperative period	70% of the fee schedule or contracted /negotiated rate
79	Unrelated procedure or service by the same physician during the postoperative period	100% of the fee schedule or contracted /negotiated rate
90	Reference (outside) laboratory	100% of the fee schedule or contracted/ negotiated rate
91	Repeat clinical diagnostic lab test	100% of the fee schedule or contracted /negotiated rate
93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system	100% of the fee schedule or contracted /negotiated rate
95	Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system (but it is not required)	100% of the fee schedule or contracted /negotiated rate
99	Multiple modifiers (same line, same code)	100% of the fee schedule or contracted /negotiated rate
AJ	Clinical social worker	100% of the fee schedule or contracted /negotiated rate
cs	Cost-sharing waiver for COVID-19 testing	100% of the fee schedule or contracted /negotiated rate
CT	Computed Tomography (CT) imaging furnished using equipment that does not meet the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard	80% of the fee schedule or contracted /negotiated rate
FQ	The service was furnished using audio-only communication technology	100% of the fee schedule or contracted /negotiated rate
GO	Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke	100% of the fee schedule or contracted /negotiated rate
GQ	Telehealth services via an asynchronous telecommunications system	100% of the fee schedule or contracted /negotiated rate
GT	Telehealth services via interactive audio and video telecommunications systems	100% of the fee schedule or contracted /negotiated rate
JW	Drug amount discarded/not administered to any patient from single-use vials or single-use packages that are appropriately discarded. (Separate line item from the used amount billed without the	100% of the fee schedule or contracted /negotiated rate

	modifier) - JW not permitted when the actual dose of the drug administered is less than the HCPCS billing unit	
JZ	Drug with no discorded amount from the single-dose viol or single-use package	100% of the fee schedule or contracted /negotiated rate
PA	Surgical or other invasive procedures on the wrong body port	0% of the fee schedule or contracted /negotiated rate
PB	Surgical or other invasive procedures on the wrong patient	0% of the fee schedule or contracted /negotiated rate
PC	Wrong surgery or other invasive procedure on the patient	0% of the fee schedule or contracted /negotiated rate
PT	Colorectal cancer screening test; converted to diagnostic test or other procedure	100% of the fee schedule or contracted /negotiated rate.
Q5	Service furnished under a reciprocal billing arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area.	100% of the fee schedule or contracted /negotiated rate
Q6	Service furnished under a fee-for-time compensation arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area.	100% of the fee schedule or contracted /negotiated rate
QW	To be recognized as a test that can be performed in a facility possessing a CLIA Certificate of Waiver	100% of the fee schedule or contracted /negotiated rate
SA	Nurse practitioner rendering service in collaboration with a physician	100% of the fee schedule or contracted /negotiated rate
SB	Nurse midwife	100% of the fee schedule or contracted /negotiated rate
SL	State supplied vaccine	0% of the fee schedule or contracted /negotiated rate
SU	Procedure performed in physician's office (to denote use of facility and equipment)	0% of the fee schedule or contracted /negotiated rate
TC	Technical Component	100% of the fee schedule or contracted /negotiated rate
TM	Individualized Education Program (IEP)	100% of the fee schedule or contracted /negotiated rote except claims for school-age children with IEP program will be fully denied as member responsibility

Distinct Procedure Modifiers

Distinct Procedural Service Modifiers are used only to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. It should only be used if no other modifier more appropriately describes the relationship of the two or more procedure codes.

The submission of modifiers 59 or X{EPSU} appended to a procedure code indicates that documentation is available in the Member's medical record which will support the distinct or independent identifiable nature of the service submitted with modifier XE, XP, XS, XU, or 59, and that the records will be provided in a timely manner for review upon request.

59	Distinct Procedural Service	100% of the fee schedule or contracted /negotiated rate
XE	Separate Encounter, A service that is distinct because it occurred during a separate encounter.	100% of the fee schedule or contracted /negotiated rate
XS	Separate Structure, A service that is distinct because it was performed on a separate organ/structure.	100% of the fee schedule or contracted /negotiated rate
XP	Separate Practitioner, A service that is distinct because it was performed by a different practitioner.	100% of the fee schedule or contracted /negotiated rate
XU	Unusual Non-Overlapping Service is the use of a service that is distinct because it does not overlap the usual components of the main service.	100% of the fee schedule or contracted /negotiated rate

Modifiers X{EPSU} and/or 59 do not bypass multiple surgery fee reductions, bilateral fee adjustments, or any other administrative policy other than clinical edits. Community Health Options follows CMS National Correct Coding Initiative (NCCI) Procedure-to-Procedure edit guidelines.

Anesthesia Modifiers

Anesthesia modifiers are used to receive the correct payment of anesthesia services. Pricing modifiers must be placed in the first modifier field to ensure proper payment (AA, AD, QK, QX, QY, and QZ). Informational modifiers are used in conjunction with pricing modifiers and must be placed in the second modifier position (QS, GS, G9, and 23).

Modifier	Modifier Description	Reimbursement Impact Notes
AA	Anesthesia services performed personally by an anesthesiologist	100% of the fee schedule or contracted /negotiated rate
AD	Medical supervision by a physician; more than four concurrent anesthesia procedures	([Base Unit Value of 3 + 1 Additional Unit if medical records/anesthesia notes indicate the physician was present during induction] x Contracted Conversion Factor) x Modifier Percentage
G8	Monitored anesthesia care (MAC) for deep complex, complicated or markedly invasive surgical procedure	100% of the fee schedule or contracted /negotiated rate
G9	Monitored anesthesia care (MAC) for a patient who has a history of severe cardiopulmonary condition	100% of the fee schedule or contracted /negotiated rate

QK.	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	50% of the fee schedule or contracted /negotiated rate
QS	Monitored anesthesia core service	100% of the fee schedule or contracted /negotiated rate

QX	CRNA service; with medical direction by a physician	50% of the fee schedule or contracted /negotiated rate
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist	50% of the fee schedule or contracted /negotiated rate
QZ	CRNA service; without medical direction by a physician	100% of the fee schedule or contracted /negotiated rate
23	Unusual anesthesia: Used to report a procedure that usually requires either no anesthesia or local anesthesia but must be done under anesthesia because of unusual circumstances. Coverage/payment will be determined on a "by-report" basis.	100% of the fee schedule or contracted /negotiated rate
47	Anesthesia by surgeon:Used to report regional or general anesthesia provided by the surgeon.	100% of the fee schedule or contracted /negotiated rate
P1 - P6	Physical status modifiers	P1: No increase P2: No increase P3: one additional unit P4: two additional units P5: three additional units

Assist at Surgery Modifiers

Assistant at surgery services are those services rendered by physicians or non-physician practitioners who actively assist the physician in charge of performing a surgical procedure.

Modifier	Modifier Description	Reimbursement Impact Notes
80	Assistant surgeon	16% of the fee schedule or contracted /negotiated rate
81	Minimum assistant surgeon	16% of the fee schedule or contracted /negotiated rate
82	Assistant surgeon: when a qualified resident surgeon is not available	16% of the fee schedule or contracted /negotiated rate
AS	Physician Assistant (PA), Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS) assistant at surgery services	14% of the fee schedule or contracted /negotiated rate

Durable Medical Equipment (DME) Modifiers

Modifier	Rental Modifier Description
RR	Rental
KH	Initial Claim, first-month rental
Kl	Second or third monthly rental
KJ	Copped rental months four to fifteen
KR	Partial Month

Modifier	Purchase Modifier Description
NU	New Equipment
UE	Used Equipment
NR	New when rented
KM	Replacement of facial prosthesis including new impression/moulage
KN	Replacement of facial prosthesis using previous master model

Ambulance Origin/Destination Modifiers

Modifier	Modifier Description
D	Diagnostic or therapeutic site other than 'P' or 'H' when these codes are used as origin codes. This modifier is to be used for transport to or from an ambulatory surgical center (ASC) or a free-standing psychiatric facility.
E	Residential, domiciliary, custodial facility (other than an 1819 facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital: This modifier must be submitted for a psychiatric facility located at a hospital.
I	Site of transfer (e.g., airport or helicopter pad) between types of ambulance vehicles
J	Non-hospital-based dialysis facility
N	Skilled nursing facility (SNF) (7819 Facility)
p	Physician's office (includes HMO non-hospital facility, clinic, etc.)
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 (includes HMO non-hospital facility, clinic, etc.)

In addition, institutional-based providers must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:

QM - Ambulance service provided under arrangement by a provider of services; or
QN - Ambulance service furnished directly by a provider of services.

Anatomic Modifiers

Append to a service that is performed on the hands, feet, eyelids, coronary artery or left and right side of the body.

Side of Body Modifiers

LT	Left side of body	RT	Right side of body

Bilateral surgical codes billed separately under LT and RT will be denied if the surgical code is eligible to be billed using modifier 50.

Eyelid Modifiers

E1	Upper left, eyelid	E3	Upper right, eyelid
E2	Lower left, eyelid	E4	Lower right, eyelid

Hand Modifiers

FA	Left hand, thumb	F5	Right hand, thumb
F1	Left hand, second digit	F6	Right hand, second digit
F2	Left hand, third digit	F7	Right hand, third digit
F3	Left hand, fourth digit	FS	Right hand, fourth digit

Feet Modifiers

TA	Left foot, great toe	TS	Right foot, great toe
T1	Left foot, second digit	T6	Right foot, second digit
T2	Left foot, third digit	T7	Right foot, third digit
T3	Left foot, fourth digit	TS	Right foot, fourth digit

Coronary Artery Modifiers

LC	Left circumflex coronary artery	RC	Right coronary artery
LD	Left anterior descending coronary artery	LM	Left main coronary artery
RI	Ramus Intermedius		

Chiropractic Modifier

AT	Acute or Active Treatment

Physician Quality Reporting System (PQRS) Modifiers

Performance measure modifiers are used to indicate special circumstances of a patient's encounter with the physician.

1P	Performance Measure Exclusion Modifier due to Medical Reasons
2P	Performance Measure Exclusion Modifier due to Patient Reasons
3P	Performance Measure Exclusion Modifier due to System Reasons
SP	Performance Measure Reporting Modifier - action not performed; reason not otherwise specified

Informational Therapy Modifiers

Used to identify type of therapy service and level of functional impairment

Outpatient Therapy Code Modifiers: Identify discipline of plan of care under which service is delivered.

CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapist assistant (OTA) ***(reported with*** GO ***therapy modifier)***
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant (PTA) ***(reported with GP therapy modifier)***
GN	Services delivered under an outpatient speech-language pathology plan of care
GO	Services delivered under an outpatient occupational therapy plan of care
GP	Services delivered under an outpatient physical therapy plan of care

KX	Used to indicate the services rendered are medically necessary

Related Policies

Ambulance Services
Anesthesia Professional Services
Telemedicine/Telehealth Services
Physician Assistant Services

Document Publication History

- 3/7/2023 Added (1) Q5 & Q6 modifiers for Reciprocal Billing Arrangements and Fee-for Time Compensation Arrangements (formerly referred to as Locum Tenens Agreements) (2) PT modifier for colorectal screening (3) Moved 59 to its own Distinct Procedure Modifier section and added associated X{EPSU} modifiers.
- 12/2/2022 Updated (1) 78 modifier from 80% to 70% effective 2/15/2023 (2) added JW modifier not permitted if administration less than HCPCS billing unit (3) added JZ modifier effective 1/1/2023 (4) added note under LT/RT not allowed if surgical code eligible to be billed with modifier 50
- 6/21/2022 Annual review; added modifiers 93 & FQ
- 7/9/2021 Initial publication
