



Network Notification

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To: Ohio & Michigan Providers

From: CareSource

Subject: Modifier Definitions

The modifier definitions listed below are a high-level review of the most commonly used modifiers. It is not an all-inclusive list. For a complete list of modifiers, please refer to the CPT or HCPCS coding books, or EncoderPro online. This will ensure the claim is coded properly.

Modifier – Quick Finder

NOTE: Click on the modifier description, which will link to the full definition

E = E/M A = Anesthesia S = Surgery R = Radiology P = Path/Lab M = Medicine

MODIFIER	E	A	S	R	P	M	DESCRIPTION
-22		√	√	√	√	√	Unusual Services – Increased Procedural Service
-24	√						Unrelated E/M Service by the Same Physician during a Post-Op Period
-25	√						Significant, Separately Identifiable E/M Service By the Same Physician on the Same Day of the Procedure or Other Service
-26			√	√	√	√	Professional Component
-47			√				Anesthesia by Surgeon (Regional or general)
-50			√	√			Bilateral Procedure
-51		√	√	√		√	Multiple Procedures
-52	√		√	√	√	√	Reduced Service
-53		√	√	√	√	√	Discontinued Procedure
-54			√				Surgical Care Only
-55			√			√	Postoperative Management Only

-56			√			√	<u>Preoperative Management Only</u>
-57	√						<u>Decision for Surgery</u>
-58			√	√		√	<u>Staged or Related Procedure or Service by the Same Physician during Post-Op Period</u>
-59		√	√	√	√	√	<u>Distinct Procedural Service</u>
-62			√				<u>Two Surgeons</u>
-66			√				<u>Surgical Team</u>
-73			√	√		√	<u>Discontinued Output Hospital/ASC Procedure Prior to Anesthesia</u>
-74			√	√		√	<u>Discontinued Output Hospital/ASC Procedure After the Anesthesia</u>
-76			√	√		√	<u>Repeat Procedure or Service by the Same Physician</u>
-77			√	√		√	<u>Repeat Procedure or Service by Another Physician</u>
-78			√	√		√	<u>Unplanned Return to the Operating/Procedure Room by the Same Physician for a Related Procedure during the Post-Op Period</u>
-79			√	√		√	<u>Unrelated Procedure or Service by the Same Physician during the Post-Op Period</u>
-80			√	√		√	<u>Assistant Surgeon</u>
-81			√	√		√	<u>Minimum Assistant Surgeon</u>
-82			√	√		√	<u>Assistant Surgeon (when qualified resident surgeon not available)</u>
-90				√			<u>Reference (outside) Laboratory</u>
-91				√			<u>Repeat Clinical Diagnostic Laboratory Test</u>
-99	√	√	√	√	√	√	<u>Multiple Modifiers</u>
-AA		√					<u>Anesthesia Services Performed Personally by Anesthesiologist</u>
-AD		√					<u>Medical Supervision by a Physician; more than 4 Concurrent Anesthesia Procedures</u>
-AS			√			√	<u>Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist Services for Assistant at Surgery</u>
-GN						√	<u>Services Delivered under an Output Speech Language Pathology Plan of Care</u>
-GO						√	<u>Services Delivered Under an Outpatient Occupational Therapy Plan of Care</u>
-GP						√	<u>Services Delivered under an Output Physical Therapy Plan of Care</u>
-LT			√	√		√	<u>Left Side (used to identify procedures performed on the left side of the body)</u>
-Q5	√	√	√	√	√	√	<u>Service Furnished by a Substitute Physician under a Reciprocal Billing Arrangement</u>
-Q6	√	√	√	√	√	√	<u>Service Furnisher by a Locum Tenens Physician</u>

-QW					√		<u>CLIA Waived Test</u>
-QX		√					<u>CRNA Service; with Medical Direction by a Physician</u>
-QY		√					<u>Medical Direction of one CRNA by an Anesthesiologist</u>
-QZ		√					<u>CRNA Service; without Medical Direction by a Physician</u>
-RT			√	√		√	<u>Right Side (used to identify procedures performed on the right side of the body)</u>
-SA	√		√			√	<u>Nurse Practitioner Rendering Service in Collaboration with a Physician</u>
-SB	√		√			√	<u>Nurse Midwife Rendering Service in Collaboration with a Physician</u>
-TC			√	√	√	√	<u>Technical Component</u>
-TH	√	√	√	√			<u>Obstetrical Treatment/Services, Prenatal or Postpartum</u>
-UC	√		√			√	<u>Clinical Nurse Specialist Rendering Service in Collaboration with a Physician (Ohio Medicaid)</u>
-UD	√		√			√	<u>Physician Assistant Rendering Service in Collaboration with a Physician (Ohio Medicaid)</u>
-UD	√						<u>Physician Billing for the Emergency Department E/M Service when the Patient was released from the ER (Michigan Medicaid)</u>

Modifier Definitions

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 additional work.

Examples:

- Increased intensity
- Time
- Technical difficulty of procedure
- Severity of patient's condition
- Physical and mental effort required

The reimbursement for a procedure already takes into account that sometimes the procedure will be simpler and other times more difficult. Therefore, it's critical that documentation support the unexpected additional time and effort above a normal encounter with the specific procedure(s). Documentation should be submitted with the claim.

Modifier - 24 Unrelated E/M by the Same Physician During a Post-Operative Period

The physician may need to indicate that an evaluation and management service was performed during a post-operative period for reasons unrelated to the original procedure. This may be reported by adding Modifier 24 to the appropriate level of E/M service.

Why it's Critical to Add Modifier 24?

CareSource's software will automatically deny a claim for an E/M service if the claim is submitted by the same provider during the post-operative period with the **same diagnosis** for which the procedure was performed. Clinical notes are required and **MUST** be sufficiently documented to establish that the visit was **unrelated** to the surgery.

Modifier 25 - Significant, Separately Identifiable E/M Service by the Same Physician on the Same Day of the Procedure or Other 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 the other service provided or beyond the usual pre-operative and post-operative care associated with the procedure that was performed.

A significant, separately identifiable E/M service is defined or substantiated by documentation.

Important Tips:

- When the only service provided is the procedure, an E/M code may **not** be appropriate
- Prepayment and or post payment review may be required
- Documentation (clinical notes, medical records, operative reports) must clearly indicate the elements (history, physical exam, medical decision making) for the E/M, and prove that it is significant and separate from the routine pre and post-operative care related to the procedure
- If there is more than one diagnosis being addressed and/or affecting treatment and/or outcomes, then an E/M code may be appropriate
- If there are signs, symptoms and/or conditions the physician must address before deciding to perform a procedure or service, then an E/M code may be appropriate

Modifier 26 - Professional Component

Certain procedures are a combination of a physician component and a technical component. The professional component reflects physician time and intensity in furnishing the service, including activities before and after direct patient contact. When the physician component is reported separately, the service may be identified by adding Modifier 26 to the usual procedure number.

- **TC Technical Component**

The Technical Component refers to the resources used in furnishing the service, such as office rent, wages of personnel and other office practice expenses. When only the technical component is performed, the Modifier TC should be added to the appropriate CPT code to identify the service.

- **Global CPT Codes**

Global CPT codes comprise the Professional and Technical Components. If both components of care are rendered, it is not necessary to append a modifier to the code. However, the remote monitoring codes are an example of a global service that requires two different CPT codes to be billed together, as one code represents the Professional Service and another code represents the Technical Service (e.g., CPT 93294 - 93299).

***Codes that are "professional" by nature and would not require Modifier 26. For additional questions, please refer to the CPT/HCPCS book or EncoderPro.**

Modifier 47 - Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures.

Modifier 50 - Bilateral Procedure

Bilateral procedures that are performed at the same operative session should be identified by adding Modifier 50 to the appropriate 5-digit code.

Important Tips:

- Do not use modifier 50 when the code descriptor indicates bilateral or unilateral
- Use Modifier 50 to describe procedures performed on both sides of the body (mirror image) at the same operative session
- Use Modifier 50 for surgical procedures
- CareSource requires one line with Modifier 50 for bilateral procedures (two line methods will be denied)
- When a procedure descriptor indicates a bilateral procedure and is performed unilaterally, use Modifier 52, Reduced Services

CareSource follows the direction of the Centers for Medicare/Medicaid Services (CMS) concerning reimbursement of bilateral status codes. Please contact CareSource for more details on its [Bilateral Payment Policy](#).

Modifier 51 - Multiple Procedures

When multiple procedures, other than E/M services, physical medicine and rehabilitation services or provision of supplies (e.g., vaccines), 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 adding Modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes (see Appendix D in the CPT book).

Important Tips:

- Use when multiple procedures are performed on the same day at the same operative session
- List the major procedure first, with additional, less critical procedures secondary with Modifier 51
- Multiple endoscopy payment rules apply if the procedure is billed with another endoscopy in the same family
- Do not append Modifier 51 to add-on codes
- Do not append Modifier 51 to Modifier 51 exempt procedure codes
- When the delivery of twins is billed, one method of reporting is to use the appropriate CPT code with Modifier 51 appended to the second procedure (e.g., 59400 and 59409 51)

Modifier 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 Modifier 52, indicating the service is reduced.

This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient 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 (see modifiers approved for ASC hospital outpatient use).

Modifier 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. This circumstance may be reported by adding Modifier 53 to the code reported by the physician for the discontinued procedure. 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 (see modifiers approved for ASC hospital outpatient use).

Modifier 54 - Surgical Care Only

When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding Modifier 54 to the usual procedure number.

Modifier 55 – Post-operative Management Only

When one physician performed the post-operative management and another physician performed the surgical procedure, the post-operative component may be identified by adding Modifier 55 to the usual procedure number.

Modifier 56 - Preoperative Management Only

When one physician performed the pre-operative care and evaluation and another physician performed the surgical procedure, the pre-operative component may be identified by adding Modifier 56 to the usual procedure number.

Modifier 57 - Decision for Surgery

An evaluation and management 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. E/M services on the day before or on the day of major surgery (90-day global period), which result in the initial decision to perform the surgery are not included in the global surgery payment. These E/M services may be billed separately and identified with the 57 Modifier.

This modifier should not be used for visits furnished during the global period of minor procedures (0 or 10-day global period) unless the purpose of the visit is a decision for major surgery. This modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. When the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine pre-operative service and a visit or consultation is not billed in addition to the procedure. See Modifier 25.

For more information, see the Modifier 57 and E/M Payment Policy.

Modifier 58 - Staged or Related Procedure, or Service By the Same Physician During the Post-operative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (1) planned or anticipated (e.g., staged), (2) more extensive than the original procedure, or (3) for therapy following a surgical procedure. This circumstance may be reported by adding Modifier 58 to the staged or related procedure. Note: For treatment of a problem that requires a return to the operating/procedure room (e.g., unanticipated clinical condition), see Modifier 78.

Modifier 59 - Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation **must** indicate that the reported procedures represent one or more of the following to meet the criteria for using Modifier 59.

- *A different session*
- *A different procedure or surgery*
- *A different site or organ system*
- *A separate incision/excision*
- *A separate lesion*
- *A separate injury (or area of injury in extensive injuries)*

However, when another established modifier is appropriate, it should be used rather than Modifier 59. Modifier 59 should only be used if there's not another suitable descriptive modifier available, and Modifier 59 best explains the circumstances.

Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see Modifier 25.

Modifier 59 is allowable for radiology services. It may also be used with surgical or medical codes in appropriate circumstances. When billing, report the first code without a modifier. On subsequent lines, report the code with the modifier.

Important Tip on Modifier 59:

- All claims billed with a Modifier 59 require notes
- Lab & radiology will require the ordering physician's request
- All others require chart/op notes indicating why it is necessary to unbundle these services

Modifier 62 - Two Surgeons

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding Modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons.

Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may also be reported with 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 code(s) with Modifier 80 or Modifier 82 added, as appropriate.

Modifier 66 - Surgical Team

Under some circumstances, highly-complex procedures (requiring the services of several physicians, often of different specialties, plus other 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 Modifier 66 to the basic procedure number used for reporting services.

Modifier 73 Discontinued Outpatient Hospital/Ambulatory Surgery Center (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 (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for, but cancelled, can be reported by its usual procedure number and the addition of 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. For physician reporting of a discontinued procedure, see Modifier 53.

Modifier 74 - Discontinued Outpatient Hospital/Ambulatory Surgery Center (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 (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc).

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. For physician reporting of a discontinued procedure, see Modifier 53.

Modifier 76 - Repeat Procedure or Service by Same Physician

It may be necessary 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/service.

Modifier 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/service.

*This modifier is allowable for radiology services. It may also be used with surgical or medical codes in appropriate circumstances.

Modifier 78 - Unplanned Return to the Operating/Procedure Room by the Same Physician

Following initial procedure for a related procedure during the post-operative period, it may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure).

When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding Modifier 78 to the related procedure. (For repeat procedures, see Modifier 76.)

Modifier 80 - Assistant Surgeon

Surgical assistant services may be identified by adding Modifier 80 to the usual procedure number(s).

Modifier 81 - Minimum Assistant Surgeon

Minimum surgical assistant services are identified by adding Modifier 81 to the usual procedure number.

Modifier 82 - Assistant Surgeon (when qualified resident surgeon not available)

The unavailability of a qualified resident surgeon is a prerequisite for use of Modifier 82 appended to the usual procedure code number(s).

Modifier 90 - Repeat Clinical Diagnostic Laboratory Test

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding Modifier 90 to the usual procedure number.

Modifier 99 - Multiple Modifiers

Under certain circumstances, two or more modifiers may be necessary to completely delineate a service. In such situations, Modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

Modifier AA - Anesthesia Services Performed Personally by Anesthesiologist

Modifier AA is used when a physician assists the surgeon with anesthesia service in the care of the patient, and the anesthesia is considered personally performed by the physician.

Modifier AD - Medical Supervision by a Physician: More than 4 Concurrent Anesthesia Procedures

Modifier AD is used when the anesthesiologist/physician is supervising more than four anesthesia procedures at one time. The physician may not need to stay in one surgical suite during the entire procedure but may monitor several rooms at one time.

Modifier AS - Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Services for Assistance at Surgery

To qualify as an assistant surgeon, the surgeon must actively assist when a physician performs a covered surgical procedure. A physician's assistant or other non-physician provider who assists at surgery would not use Modifier 80.

Modifier GN - Services Delivered Under Outpatient Speech Language Pathology Plan of Care

This modifier is used for outpatient speech rehabilitation services.

Modifier GO - Services Delivered Under Outpatient Occupational Therapy Plan of Care

This modifier is used for outpatient speech rehabilitation services.

Modifier GP - Services Delivered Under an Outpatient Physical Therapy Plan of Care

This modifier is only reported when the service is performed as a part of the therapy plan of care. These services are "sometimes therapy" codes that can be performed by non-therapists. Report this

modifier only when a qualified therapist performs the service. If a non-therapist performs the service, do not report this modifier.

Modifier LT - Left Side (used to identify procedures performed on the left side of the body)

Procedures that are on the left side of the body.

Modifier RT - Right Side (used to identify procedures performed on the right side of the body)

Procedures that are on the right side of the body.

Modifier Q5 - Service by a Substitute Physician Under a Reciprocal Billing Arrangement

Reciprocal billing allows a physician to submit claims and receive Medicare payments for services that he has arranged for a substitute physician to provide on an occasional, reciprocal basis.

Modifier Q6 - Service Furnished by a Locum Tenens Physician

The regular physician bills for services and attaches Q6 Modifier when a locum tenens physician actually performs the services when the regular physician is absent.

Modifier QW - CLIA Waived Test

The QW modifier states that the tests you are performing are simple laboratory examinations and procedures that have an insignificant risk of an erroneous result. They are considered "CLIA waived" and therefore require a "CLIA Certificate of Waiver."

Modifier QX - CRNA Service with Medical Direction by a Physician

Physician services may be reimbursed at the medically directed rate if the physician medically directs qualified individuals in two, three or four concurrent cases and performs the following activities:

- Performs a pre-anesthetic exam and evaluation (must be documented in the patient's medical records)
- Prescribes the anesthesia plan
- Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence (physician presence must be documented in the patient's medical record)
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist
- Monitors the course of anesthesia administration at frequent intervals (physician presence during some portion of anesthesia monitoring must be documented in the patient's medical records)
- Remains physically present and available for immediate diagnosis and treatment of emergencies
- Provides indicated post-anesthesia care (must be documented in the patient's medical records)

Modifier QY - Medical Direction of one CRNA by an Anesthesiologist

An anesthesiologist may bill the "QY" modifier if he/she provides medical direction to an anesthesiologist assistant/CRNA.

Modifier QZ - CRNA Service Without Medical Direction by a Physician

CRNA would use this modifier when performing services without medical direction by a physician.

Modifier SA - Nurse Practitioner Rendering Service in Collaboration with a Physician

A supervising physician should use this modifier when billing on behalf of a nurse practitioner for non-

surgical services. (Modifier SA is used when the nurse practitioner is assisting with any other procedure that *DOES NOT* include surgery.

Modifier SB - Nurse Midwife Rendering Service in Collaboration with a Physician

The SB modifier is used to designate that the nurse midwife performed the service.

Modifier TC - Technical Component

Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding Modifier TC to the usual procedure number.

Technical component charges are institutional charges and not billed separately by physicians. However, portable x-ray suppliers only bill for technical component and should utilize Modifier TC. The charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.

Modifier TH - Obstetrical Treatment/Services, Prenatal or Postpartum

Modifier TH should be used on each visit for OB services prenatal through postpartum.

Modifier UC - Clinical Nurse Specialist Rendering Service in Collaboration with a Physician

(Ohio Medicaid) Bill the Modifier UC, for example 99201UC, if the APN is a clinical nurse specialist.

Modifier UD - Physician Assistant Rendering Service in Collaboration with a Physician

(Ohio Medicaid) A physician, physician group practice, or clinic must bill for physician assistant services using the UD Modifier signifying that a physician assistant provided the service.

Modifier UD - Physician Billing for the ED E/M Service when Patient was Released from the ER

(Michigan Medicaid) When billing for the attending **ED physician** E/M service, the modifier UD must be used with the appropriate E/M procedure code to designate that the beneficiary was released (discharged) from the ED. This modifier must be placed in the first modifier position on the claim line to ensure correct processing.

The UD modifier indicates the physician billing for the ED E/M service was the attending ED physician and allows the appropriate fee screen to be used. E/M services provided by other physicians in the ED must not use the UD Modifier. Services billed in addition to the E/M service by the attending ED physician must not use the UD Modifier.