Billing and Reimbursement Guideline:	Modifier Billing and Reimbursement

Guideline Publication Date:	September 1, 2010

Ambulance Origin and Destination Modifiers

Each line of an ambulance claim must use two single alphabetical modifiers to identify both the point of origin of the pickup and the destination of the patient.

- Each ambulance trip for a patient must be coded on a separate claim unless the second trip is within the same zip code as the first.

- Origin and destination modifiers are single digit modifiers. The first single digit indicates the origin of the trip and the second single digit modifier indicates the destination of the patient.

- The following table lists ambulance origin and destination modifiers:

D	Diagnostic or therapeutic site other than "P" or "H" (includes free-standing facilities)
E	Residential, domiciliary, custodial facility (includes nonparticipating facilities).
G	Hospital-based dialysis facility (hospital or hospital-related).
H	Hospital (includes OPD or ER)
I	Site of Transfer (e.g., airport or helicopter pad) between modes of ambulance transfer.
J	Non hospital-based dialysis facility (free standing).
N	Skilled Nursing Facility (Medicare participating only).
P	Physician's office.
R	Residence
S	Scene of accident or acute event.
X	Intermediate stop at physician's office on the way to the hospital(destination only).

- Claims billed without origin and destination modifiers will be denied for lack of modifiers.

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Assistants at Surgery, Modifiers 80, 81, 82 and AS

An assistant at surgery is a physician who actively assists the physician in charge of the case in performing a surgical procedure. The presence of an assistant at surgery must be medically necessary and appropriate for the surgical procedure. Neighborhood Health Plan of RI currently accepts the following modifiers that were developed to report assistant surgeon services. The differences between the modifiers are important in the correct reimbursement of the provider.

• Modifier 80 – is a physician who is an assistant surgeon who fully assists in the surgery. Reimbursed at 20% of allowed fee schedule.

• Modifier 81 – is for minimal assistance and indicates that the surgeon did not assist for the entire surgery but for a limited amount of time. Reimbursed at 15% of allowed fee schedule.

• Modifier 82 – was developed to be used only at teaching hospitals. It identifies that the teaching facility does not have a teaching program that is related to the medical specialty required by the surgical procedure or there is no qualified resident available, or the surgeon does not use residents or interns during the surgery. Reimbursed at 20% of allowed fee schedule.

• Modifier AS – the assistant at the surgery was a non-physician provider such as a PA, NPP, or clinical nurse specialist licensed in that state to act as an assistant at surgery. This modifier should not be billed by a physician. PA's are paid at 13.6% of the allowed fee schedule for an assistant at surgery.

- Two assistant surgeons may be required for certain procedures. Each surgeon should bill with an assistant surgeon modifier. If the procedure performed is approved by the AMA for multiple assistant surgeon reimbursement, payment will be considered.

- If a procedure does not call for an assistant(s), the service will be denied.

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Team and Co-Surgeons, Modifiers 62 and 66

Two surgeons or a team of surgeons may be required to perform a surgical procedure due to the complexity of the procedure or the patient's medical status. Modifiers 62 and 66 are used to indicate that two providers or a surgical team are billing for the same procedure on the same patient.

- All procedures performed by co-surgeons or a team of surgeons must have appropriate documentation to establish the medical necessity for two surgeons. In most instances, payment for an assistant surgeon is not allowed unless clear and compelling medical documentation can support the medical necessity.

- When two surgeons or a surgical team are either authorized or approved for claim payment, each surgeon is paid 62.5% of the total global surgical fee under Neighborhood Health Plan of RI payment guidelines.

- Services billed with modifier 62 or 66 may require notes.

- If a procedure does not call for a co-surgeon or a team of surgeon, the service will be denied.

Level II (HCPCS/National) Modifiers
Level II National HCPS modifiers were developed to expand the information provided by CPT codes by the AMA and CMS. The modifiers are in the form of two characters, numbers, letters or a combination of numbers and letters and are used to provide additional information regarding the anatomical location of procedures or services.

The following details the anatomical modifiers listed in the current CMS procedure code manual:

- E1 Upper left, eyelid
- E2 Lower left, eyelid
- E3 Upper right, eyelid
- E4 Lower right, eyelid
- F1 Left hand, second digit

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- 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
- LC Left circumflex coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
- LD Left anterior descending coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
- LT Left side (used to identify procedures performed on the left side of the body
- OM Ambulance service provided under arrangement by a provider of services
- UN Ambulance service furnished directly by a provider of services
- RC Right coronary artery (Hospitals used with codes 92980-92984, 92995, 92996)
- RT Right side (used to identify procedures performed on the right side of the body)
- 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

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Multiple Surgical Modifiers 50, 51 and 59

Modifiers 50, 51, and 59 are used when billing multiple surgical services performed during the same operative session. As these modifiers alter fee schedule reimbursement rates, proper billing is critical.

- Bilateral procedures should be billed on a **single** claim line, with a unit of one and modifier 50.

- If the CPT code billed does not allow for bilateral billing, the charge will be denied for incorrect modifier.

- Modifier 51 (multiple surgical services) should be used when more than one surgical service are billed for the same date of service. The most significant procedure should be listed first and does not need the modifier, and all other surgical lines (except add-on codes, such as 69990, or those exempt from modifier 59, such as 17004) will need modifier 51 listed in order for the claim to be paid. **Providers must determine which service is more extensive and considered the primary procedure.**

- NHPRI currently reimburses the first procedure at 100% of fee schedule, the second at 50%, and the third, fourth, and fifth at 25%. The sixth procedure and greater are considered global.

- Modifier 59 (significant, separately identifiable service) should only be used to identify multiple surgical services that cannot be billed with modifier 51. Neighborhood allows 100% of the contracted fee schedule. Notes may be requested to support separate payment.

- Multiple surgical services billed without appropriate modifiers will be denied for missing/invalid modifiers. Modifiers are also required when requesting separate reimbursement for procedures that have been denied or are considered global to another procedure.

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Return to the Operating Room, Modifiers 58 and 78

Modifiers 58 and 78 are used on surgical codes to indicate procedures that are performed during the postoperative period of the initial surgery. These modifiers typically reimburse 69% of the allowed fee schedule.

- Services that do not require a return to the operating room cannot be billed with this modifier.
- The physician must bill the procedure code that best describes the surgical procedures performed.
- The initial procedure code should not be billed unless the exact identical procedure is performed again.
- An operating room is defined as a specifically equipped and staffed place of service for the sole purpose of performing procedures. The term "operating room" includes the cardiac catheterization suite, a laser suite, or an endoscopy suite in addition to the formal operating suites within a hospital or ASC.
- The only time a procedure would be reimbursed for treatment of a complication outside the operating room is when the patient's condition was so critical that transport to the operating room would have been detrimental to the patient's care. Medical records are required to substantiate medical necessity.
- A new postoperative period does not begin when the procedure performed to treat the complication is performed.
- When a procedure with a 000 global period is performed to treat complications, the follow up procedure is reimbursed at 100%.
- Full payment is allowed for the treatment of complications by another physician or surgeon. These services should not be billed with a 78 modifier.

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Separately Identifiable Services, Modifier 25

Significant separately identifiable Evaluation and Management services that are performed by the same physician on the same day as a procedure or other service should be indicated by the addition of the modifier 25 to the Evaluation and Management code.

- Modifier 25 can only be added to an Evaluation and Management (E&M) code.
- Medicare's minor surgical payment policy allows for payment of an Evaluation and Management service on the same day as a minor surgical procedure if it is "separate and identifiable." (Section 15501.1 of the Medicare Carriers Manual). The services billed under the Evaluation and Management codes need to be above and beyond the usual preoperative and postoperative care associated with the procedure.
- The patient's medical record must substantiate the need for the E&M service and all components of history, examination, medical decision making, counseling and coordination of care, and nature of the presenting problem intrinsic to the level of the code will be included in the medical documentation.

Notes may be requested to confirm documentation of a "separate and identifiable service" performed.

Surgical Modifiers 54, 55 and 56

Modifiers 54, 55, and 56 are used when only a part of the global surgical package is performed by the physician or provider. Failure to indicate the portion of the surgical package performed by the physician results in an overpayment and billing for services not rendered.

• Modifier 54 – surgical care only indicates that the physician performed only the intra-operative portion of the surgical procedure. Typically reimburses 69% of allowed fee schedule.

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• Modifier 55 – postoperative management only indicates that the physician performed only the postoperative care and management after another physician performed the surgery. Typically reimburses 21% of allowed fee schedule.

• Modifier 56 – preoperative management only indicates that the physician only provided the preoperative evaluation and management services of the global surgical package. Typically reimburses 10% of allowed fee schedule.

- These modifiers should be billed for procedures with a 90-day global period and not for procedures with zero or 10-day global periods.
- The percentages paid for these modifiers are set by contract or Neighborhood Health Plan of RI standard modifier allowances.
- If the physician providing most of the postoperative care is a part of the same group or a covering physician, the modifier 54 cannot be used by the surgeon or physician with the postoperative care 55 billed by a member of the same group.
- When using Modifier 54, there must be a notation in the record agreeing to the transfer of the postoperative care to another physician or provider.
- Modifier 55 is added to the surgery code only after the initial postoperative visit is completed by the physician providing the postoperative care.
- Modifier 55 is used only after the patient has been discharged from the hospital. If another physician sees the patient after surgery, the physician (not the surgeon) will bill using the hospital care codes.
- Modifier 56 is used in rare instances and only on surgical codes.

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Therapy Modifiers GN, GO and GP

Providers are required to report one of the modifiers listed above to distinguish the type of therapist who performed the outpatient rehabilitation services. If the service was not delivered by a therapist, then the discipline of the Plan of Treatment/Care under which the service is delivered should be reported. Key coding and reimbursement points include:

- Providers of outpatient and other therapy services are to submit modifiers GN, GO, and GP on therapy claims:

  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.

- Some of the therapy codes are considered "always" therapy and must be billed with the appropriate modifier regardless of who provides the service.

- There is a listing of codes that is updated regularly available on the CMS website of those "always therapy" codes.

- If the codes are billed without a modifier, the claim may be pended or denied for further information.

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Unusual Procedure or Service, Modifier 22

If a procedure is substantially greater than typical, the provider must document the additional work and the reason for the additional work in order to bill for additional reimbursement. Key coding and reimbursement points include:

- The 22 modifier description was significantly revised in the 2008 CPT® codes with clearly defined documentation requirements.
- This modifier is attached to the primary procedure.
- The documentation guidelines include that the reason for the additional work:
  - Increased intensity
  - Increased time
  - Increased technical difficulty
  - Severity of the patient's condition
  - Physical and mental effort required
- Neighborhood Health Plan of RI typically reimburses an additional 20% of a provider's contractual reimbursement for modifier 22 if notes support the modifier.
- This modifier is typically used on surgical procedures.
- Notes are required in order to make any financial determination.
- The anatomical modifiers can be used with the NCCI-associated edits with an indicator of "1".
- The anatomical modifiers are used when there are separate patient encounters, separate anatomic sites, or separate specimens.
- Modifier 59 is required if the procedure is considered bundled with another service on the same date. Notes may also be required for review.

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- ***This guideline applies to both CMS-1500 and UB-92 claim submissions.***

A. Covered Modifiers

Modifier	Description	Percentage reimbursed (of fee schedule or allowance for procedure)	Notes Required with claim submission?
22	Unusual Procedure	120%	On Request
23	Unusual Anesthesia	120%	On Request
24	Unrelated Evaluation	100%	On Request
25	Significant, Separately Identifiable Evaluation	100%	On Request
26	Professional Component	30%	No
27	Multiple Outpatient Hospital E/M Encounters on the same date	100%	On Request
32	Mandated Services	100%	No
47	Anesthesia by Surgeon	100%	No
50	Gen TST; Neuro NN Neo MECP2	100%	No
50	Bilateral Procedure	50%	No
51	Multiple Procedures	50%	No
52	Reduced Services	15%	No
53	Discontinued Procedure	20%	No
54	Surgical Care Only	69%	No
55	Postoperative Care Only	21%	No
56	Pre-OP Management	10%**	No
57	Decision for Surgery	100%	No

58	Staged or Related Procedure	69%	No
59	Distinct Procedural Service	100%	No
62	Two Surgeons	62%	No
63	Procedure Performed on Infants	100%	No
66	Surgical Team	62%	No
73	Discontinued Out-Patient Procedure Prior to Anesthesia Administration	50%	No
74	Discontinued Out-Patient Procedure After Anesthesia Administration	100%	No
76	Repeat Procedure by Same Physician	100%	No
77	Repeat Procedure by Another Physician	100%	No
78	Return to Operating RM for Related Procedure	69%	No
79	Unrelated Proc/Svs by Same Physician	100%	No
80	Assistant Surgeon	20%	No
81	Minimum Assistant Surgeon	15%	No
82	Assistant Surgeon when qualified resident surgeon	20%	No
90	Outside Lab	100%	No
92	Alternative Laboratory Platform Testing	100%	No
91	Repeat Clinical Diagnostic Test	100%	No

99	Multiple Modifiers	100%	No
0A	Gen TST; Neoplasia BRCA 1	100%	No
0B	Gen TST; Neoplasia BRCA 2	100%	No
0C	Gen TST; Neoplasia Neurofibromin	100%	No
0D	Gen TST; Neoplasia Merlin	100%	No
0E	Gen TST; Neoplasia c-RET	100%	No
0F	Gen TST; Neoplasia VHL	100%	No
0G	Gen TST; Neoplasia SDHD	100%	No
0H	Gen TST; Neoplasia SDHB	100%	No
0I	Gen TST; Neoplasia Her-2/NEU	100%	No
0J	Gen TST; Neoplasia MLH1	100%	No
0K	Gen TST; Neoplasia MSH2	100%	No
0L	Gen TST; Neoplasia APC	100%	No
0M	Gen TST; Neoplasia RB	100%	No
1Z	Gen TST; Neoplasia SLD TUMOR; UNSPEC	100%	No
2A	Gen TST; Neoplasia AML1 ALSO ETO	100%	No
2B	Gen TST; Neoplasia BCR ALSO ABL	100%	No
2C	Gen TST; Neoplasia CGF1	100%	No
2D	Gen TST; Neoplasia CBF BETA	100%	No

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2E	Gen TST; Neoplasia MML	100%	No
2F	Gen TST; Neoplasia PML/RAR ALPHA	100%	No
2G	Gen TST; Neoplasia TEL	100%	No
2H	Gen TST; Neoplasia BC1-2	100%	No
2I	Gen TST; Neoplasia BC1-1	100%	No
2J	Gen TST; Neoplasia C-MYC	100%	No
2K	Gen TST; Neoplasia IGH	100%	No
2Z	Gen TST; Neoplasia LYMP/HEMAT UNSPEC	100%	No
3A	Gen TST; NN Neoplasia Factor V	100%	No
3B	Gen TST; NN Neoplasia FACC	100%	No
3C	Gen TST; NN Neoplasia FACD	100%	No
3D	Gen TST; NN Neoplasia BETA GLOBIN	100%	No
3E	Gen TST; NN Neoplasia ALPHA GLOBIN	100%	No
3F	Gen TST; NN Neoplasia MTHFR	100%	No
3G	Gen TST; NN Neoplasia PROTHOMBIN	100%	No
3H	Gen TST; NN Neoplasia FACTOR VIIII	100%	No
3I	Gen TST; NN Neoplasia Factor IX	100%	No

3J	Gen TST; NN Neoplasia HEM/COAG UNSPC	100%	No
3Z	Gen TST; NN Neoplasia BETA GLOBIN	100%	No
4A	Gen TST; Blood Typing HLA-A	100%	No
4B	Gen TST; Blood Typing HLA-B	100%	No
4C	Gen TST; Blood Typing HLA-C	100%	No
4D	Gen TST; Blood Typing HLA-D	100%	No
4E	Gen TST; Blood Typing HLA-DR	100%	No
4F	Gen TST; Blood Typing HLA-DQ	100%	No
4G	Gen TST; Blood Typing HLA-DP	100%	No
4H	Gen TST; Blood Typing KELL	100%	No
4Z	Gen TST; Blood Typing UNSPEC	100%	No
5A	Gen TST; Neuro NN Neo ASPRTCYLASE	100%	No
5B	Gen TST; Neuro NN Neo FMR-1	100%	No
5C	Gen TST; Neuro NN Neo FRATAXIN	100%	No
5D	Gen TST; Neuro NN Neo HUNTINGTON	100%	No
5E	Gen TST; Neuro NN Neo GABRA	100%	No

5F	Gen TST; Neuro NN Neo CONNEXIN-26	100%	No
5G	Gen TST; Neuro NN Neo CONNEXIN-32	100%	No
5H	Gen TST; Neuro NN Neo SNRPN	100%	No
5I	Gen TST; Neuro NN Neo ATAXIN-1	100%	No
5J	Gen TST; Neuro NN Neo ATAXIN-2	100%	No
5K	Gen TST; Neuro NN Neo ATAXIN-3	100%	No
5L	Gen TST; Neuro NN Neo CACNA1A	100%	No
5M	Gen TST; Neuro NN Neo ATAXIN-7	100%	No
5N	Gen TST; Neuro NN Neo PMP-22	100%	No
5Z	Gen TST; Neuro NN Neo UNSPEC	100%	No
6A	Gen TST; Musc NN NEO DYSTROPHIN	100%	No
6B	Gen TST; Musc NN NEO CMPK	100%	No
6C	Gen TST; Musc NN NEO ZNF-9	100%	No
6D	Gen TST; Musc NN NEO SMN	100%	No
6Z	Gen TST; Musc NN NEO MUSC UNSPEC	100%	No
7A	Gen TST; MTBOL OTHR APOLIPOPROTEIN E	100%	No

7B	Gen TST; MTBOL OTHR SPHNGMYLN PHOSP	100%	No
7C	Gen TST; MTBOL ACID BETA GLUCOSIDASE	100%	No
7D	Gen TST; MTBOL HFE	100%	No
7E	Gen TST; METABOLIC UNSPEC	100%	No
7Z	Gen TST; MTBOL OTHR APOLIPOPROTEIN E	100%	No
8A	Gen TST; MTBOL TRNS CFTR	100%	No
8Z	Gen TST; METABOLIC TRANSPORT UNSPEC	100%	No
9A	Gen TST; MTBOL PARM TPMT	100%	No
9L	Gen TST; MTBOL PARM UNSPEC	100%	No
9M	Gen TST; DYSMORPHOLOGY FGFR1	100%	No
9N	Gen TST; DYSMORPHOLOGY FGFR2	100%	No
9O	Gen TST; DYSMORPHOLOGY FGFR3	100%	No
9P	Gen TST; DYSMORPHOLOGY TWIST	100%	No
9Q	Gen TST; DYSMORPHOLOGY CATCH-22	100%	No

9Z	Gen TST; DYSMORPHOLOGY UNSPEC	100%	No
A1	Dressing for One Wound	100%	No
A2	Dressing for Two Wounds	100%	No
A3	Dressing for Three Wounds	100%	No
A4	Dressing for Four Wounds	100%	No
A5	Dressing for Five Wounds	100%	No
A6	Dressing for Six Wounds	100%	No
A7	Dressing for Seven Wounds	100%	No
A8	Dressing for Eight Wounds	100%	No
A9	Dressing for 9 or more wounds	100%	No
AA	Anesthesia Performed Personally	100%	No
AD	Medical Supervision by a Physician. more than four anesth procedures	100%	No
AE	Registered Dietician	100%	No
AF	Specialty Physician	100%	No
AG	Primary Physician	100%	No
AH	Clinical Psychologist	100%	No
AJ	Clinical Social Worker	100%	No
AK	Non- Participating Physician	100%	No
AM	Physician ; Team Member Service	100%	No
AP	Determination of Refractive State	100%	No

AQ	Physician Service Unlisted HPSA	100%	No
AR	Physician provider services in a physician scarcity area	100%	No
AS	Physician Assistant; Nurse Practitioner	100%	No
AT	Acute Treatment	100%	No
AU	Item Furnished in Conjunction with a urological, ostomy, trach supply	100%	No
AV	Item Furnished in Conjunction with a prosthetic device	100%	No
AW	Item Furnished in Conjunction with a surgical dressing	100%	No
AX	Item Furnished in Conjunction with parenteral enteral nutrition services	100%	No
BA	Item Furnished in Conjunction with dialysis services	100%	No
BL	Spec Acquisition Blood Products	100%	No
BO	Orally Administered Nutrition; Not by feeding tube	100%	No

BP	The Beneficiary has been informed of the purchase and rental options and has elected to purchase the item.	100%	No
BR	The Beneficiary has been informed of the purchase and rental options and has elected to rent the item.	100%	No
BU	The Beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision	100%	No
CA	Procedure payable only in an inpatient setting when performed emergency on an outpatient who expires prior to admission.	100%	No
CB	Service ordered by a renal dialysis facility (RDF) physician as part of the ESRD beneficiary's dialysis benefit, is not part of the composite rate, and is separately reimbursable.	100%	No
CC	Procedure code change	100%	No

CD	AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable.	100%	No
CE	AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity.	100%	No
CF	AMCC test that has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable.	100%	No
CG	Innovator drug dispensed	100%	No
CR	Catastrophe/Disaster related	100%	No
DD	AMB; Diag- Ther to Diag-Ther	100%	No
DE	AMB; Diag- Ther to Nursing Home	100%	No
DG	AMB; Diag- Ther to Hosp Dialysis	100%	No
DH	AMB; Diag- Ther to Hospital	100%	No

DI	AMB; Diag- Ther to Site of Transfer	100%	No
DJ	AMB; Diag- Ther to NN HSP Dialysis	100%	No
DN	AMB; Diag- Ther to SNF	100%	No
DP	AMB; Diag- Ther to Physician Office	100%	No
DR	AMB; Diag- Ther to Residence	100%	No
DX	AMB; Diag- Ther to Hosp with Stop at DR	100%	No
E1	Upper Left; Eyelid	100%	No
E2	Lower Left; Eyelid	100%	No
E3	Upper Right; Eyelid	100%	No
E4	Lower Right; Eyelid	100%	No
EA	Erythropoetic Stimulating Agent, Anemia due to Chemotherapy	100%	No
EB	Erythropoetic Stimulating Agent, Anemia due to Radiotherapy	100%	No
EC	Erythropoetic Stimulating Agent, Anemia not due to Radiotherapy or Chemotherapy	100%	No
ED	Multiple Purpose Modifier	100%	No
EE	Multiple Purpose Modifier	100%	No
EG	AMB; NH to Hosp Dialysis	100%	No
EH	AMB; NH to Hospital	100%	No
EI	AMB; NH to Site of Transfer	100%	No
EJ	Multiple Purpose Modifier	100%	No

EM	Emergency Reserve Supply (for ESRD Beneficiaries)	100%	No
EP	Multiple Purpose Modifier	100%	No
ER	AMB; NH to Residence	100%	No
ES	PET; Equivocal_PSTV; EXT ISCHEMIA	100%	No
ET	Emergency Service	100%	No
EX	AMB; NH to Hsp with stop at DR	100%	No
F1	Left Hand; Second Digit	100%	No
F2	Left Hand; Third Digit	100%	No
F3	Left Hand; Fourth Digit	100%	No
F4	Left Hand; Fifth Digit	100%	No
F5	Right Hand, Thumb	100%	No
F6	Right Hand, Second Digit	100%	No
F7	Right Hand, Third Digit	100%	No
F8	Right Hand, Fourth Digit	100%	No
F9	Right Hand, Fifth Digit	100%	No
FA	Left Hand, Thumb	100%	No
FB	Item Provided w/o Cost to Provider	100%	No
FC	Partial Credit Received for Replaced Device	100%	No
FP	Service Provided as Part of Medicaid Family Planning Program	100%	No
G1	Most Recent Urr Reading of Less Than 60	100%	No
G2	Most Recent Urr Reading of 60 to 64.9	100%	No

G3	Most Recent Urr Reading of 65 to 69.9	100%	No
G4	Most Recent Urr Reading of 70 to 74.9	100%	No
G5	Most Recent Urr Reading of 75 or greater	100%	No
G6	ESRD Patient for Whom Less than Six Dialysis sessions have been provided a month	100%	No
G7	Pregnancy resulted from rape or incest	100%	No
G8	Monitored Anesthesia Care	100%	No
G9	Monitored Anesthesia Care	100%	No
GA	Waiver of Liability Statement on File	100%	No
GB	Claim being resubmitted for payment because it is no longer covered global payment demonstration	100%	No
GD	Multiple Purpose Modifier	100%	No
GE	Multiple Purpose Modifier	100%	No
GF	Non- Physician (e.g., NP, CRNA, CNS, PA services) in a critical access hospital.	100%	No

GG	Performance and Payment of a Screening Mammogram and Diagnostic Mammogram on the same patient, same day	100%	No
GH	Diagnostic Mammogram converted from screen mammogram on the same day	100%	No
GI	Ambulance; Hospital Dialysis to Site of Transfer/Ambulances	100%	No
GJ	"OPT OUT" Physician or Practitioner emergency or urgent service	100%	No
GK	Actual item/service ordered by physician, item associated	100%	No
GM	Multiple Patients on ambulance trip	100%	No
GN	Services delivered under an outpatient speech language pathology plan of care	100%	No
GO	Services delivered under an outpatient occupational therapy plan of care	100%	No
GP	Services delivered under an outpatient physical therapy plan of care	100%	No

GQ	Via asynchronous telecommunications system	100%	No
GR	Multiple Purpose Modifier	100%	No
GR	Ambulance; hospital based dialysis to residence	100%	No
GS	Dosage EPO/Darbepoietin Alfa- reduced	100%	No
GT	Via interactive audio and video telecommunication systems	100%	No
GV	Attending physician not employed or paid under arrangement by the patient's hospice provider	100%	No
GW	Service not related to the hospice patient's condition	100%	No
GX	Ambulance; Hospital Dialysis to Hosp with stop at doctors	100%	No
GY	Item or service statutorily excluded or does not meet the definition of a Medicare benefit	100%	No
GZ	Item or service expected to be denied as not reasonable or necessary	100%	No
H9	Court ordered	100%	No
HA	Child/Adolescent Program	100%	No
HB	Adult Program; not geriatric	100%	No

HC	Adult Program; geriatric	100%	No
HD	Pregnant/Parenting women's program	100%	No
HE	Mental Health Program	100%	No
HF	Substance Abuse program	100%	No
HG	Opiod addiction treatment program	100%	No
HH	Multiple Purpose Modifier** for all providers except AMB, should be configured to deny MNHLT	100%	No
HH	Ambulance; hospital to hospital	100%	No
HI	Integrated mental health and mental retardation/developmental disabilities program	100%	No
HJ	Employee Assistance program	100%	No
HK	Specialized mental health programs for high-risk populations	100%	No
HL	Intern	100%	No
HM	Less than bachelor degree level	100%	No
HN	Bachelors degree level	100%	No
HO	Masters degree level	100%	No
HP	Doctoral level	100%	No
HQ	Group setting	100%	No
HR	Family/Couple with client present	100%	No

HS	Family/Couple without client present	100%	No
HT	Multi-Disciplinary Team	100%	No
ID	Ambulance; site of trans to diag-ther	100%	No
IE	Ambulance; site of trans to NH	100%	No
IG	Ambulance; site of trans to hospital dialysis	100%	No
IH	Ambulance; site of trans to hospital	100%	No
II	Ambulance; site of trans to site of trans	100%	No
IJ	Ambulance; site of trans to nn hosp dialysis	100%	No
IN	Ambulance; site of trans to SNF	100%	No
IP	Ambulance; site of trans to doctor office	100%	No
IR	Ambulance; site of trans to residence	100%	No
IX	Ambulance; site of trans to hosp w stop at doctor	100%	No
JA	Administered intravenously	100%	No
JB	Administered subcutaneously	100%	No
JD	Ambulance; NN hosp dialysis to Diag- Ther	100%	No
JE	Ambulance; NN hosp dialysis to nh	100%	No
JG	Ambulance; NN hosp dialysis to hosp dialysis	100%	No

JH	Ambulance; NN hosp dialysis to hospital	100%	No
JI	Ambulance; NN hosp dialysis to site of trans	100%	No
JJ	Ambulance; NN hosp dialysis to nn hosp dialysis	100%	No
JN	Ambulance; NN hosp dialysis to SNF	100%	No
JP	Ambulance; NN hosp dialysis to dr office	100%	No
JR	Ambulance; NN hosp dialysis to residence	100%	No
JX	Ambulance; NN hosp dialysis to hsp w stop at doctors	100%	No
K0	Lower extremity prosthesis functional level 0	100%	No
K1	Lower extremity prosthesis functional level 1	100%	No
K2	Lower extremity prosthesis functional level 2	100%	No
K3	Lower extremity prosthesis functional level 3	100%	No
K4	Lower extremity prosthesis functional level 4	100%	No
KA	Add on Option/Accessory for wheelchair	100%	No
KB	Beneficiary requested upgrade for abn; more than four modifiers identified on claim	100%	No

KC	Replacement of special power wheelchair interface.	100%	No
KD	Drug or biological infused through DME	100%	No
KF	Item designated by FDA as class III device	100%	No
KG	DMEPOS item subject to DMEPOS competitive bidding program number 1	100%	No
KH	DMEPOS item; Initial claim, purchase of first month rental	100%	No
KI	DMEPOS item; second or third month rental	100%	No
KJ	DMEPOS item; parenteral enteral nutrition pump or capped rental, months four to fifteen	100%	No
KL	DMEPOS item delivered via mail	100%	No
KM	Replacement of facial prosthesis including new impression/moulage	100%	No
KN	Replacement of facial prosthesis using previous master model	100%	No
KO	Single drug unit dose formulation	100%	No
KP	First drug of multiple drug unit dose formulation	100%	No

KQ	Second or subsequent drug of a multiple drug unit dose formulation	100%	No
KR	Rental item; Billing for partial month	10%	No
KS	Glucose monitor supply for diabetic beneficiary not treated with insulin	100%	No
KT	Beneficiary resides in a competitive bidding area and travels to a non-competitive bidding area and receives item from a non-contract supplier	100%	No
KU	DMEPOS item subject to DMEPOS competitive bidding program number 3	100%	No
KV	DMEPOS item subject to DMEPOS competitive bidding program that is furnished as part of a professional service	100%	No
KW	DMEPOS item subject to DMEPOS competitive bidding program number 4	100%	No
KX	Specific required documentation on file	100%	No
KY	DMEPOS item subject to DMEPOS competitive bidding program number 5	100%	No
KZ	New coverage not implemented by managed care	100%	No

LC	Left cirumflex coronary artery	100%	No
LD	Left anterior descending coronary artery	100%	No
LL	Lease/Rental	10%	No
LR	Laboratory round trip	100%	No
LS	FDA monitored intraocular lens implant	100%	No
LT	Left side	100%	No
M2	Medicare Secondary Payer (MSP)	100%	No
ND	Ambulance; SNF to diag-ther	100%	No
NE	Multiple Purpose Modifier	100%	No
NG	Ambulance; SNF to hospital dialysis	100%	No
NH	Ambulance; SNF to hospital	100%	No
NI	Ambulance; SNF to site of trans	100%	No
NJ	Ambulance; SNF to non hosp dialysis	100%	No
NN	Multiple Purpose Modifier	100%	No
NP	Multiple Purpose Modifier	100%	No
NR	New when rented	10%	No
NS	PET; negative-positive; ext ischemia	100%	No
NU	New equipment	100%	No
NX	Ambulance; SNF to hosp w stop at doctor	100%	No
P1	Normal healthy patient	100%	No

P2	Patient w/mild systemic disease	100%	No
P3	Patient w/severe system disease	100%	No
P4	Pat w/severe syst dis const threat life	100%	No
P5	Moribund patient no survival w/operation	100%	No
PD	Ambulance; doctor office to diag-ther	100%	No
PE	Multiple Purpose Modifier	100%	No
PE	Ambulance; doctor office to residential,domiciliary,cust facility	100%	No
PG	Ambulance; doctor office to hosp dialysis	100%	No
PH	Ambulance; doctor office to hospital	100%	No
PI	Ambulance; doctor office to site of trans	100%	No
PJ	Ambulance; doctor office to non hosp dialysis	100%	No
PL	Progressive addition lenses	100%	No
PN	Multiple Purpose Modifier	100%	No
PP	Multiple Purpose Modifier	100%	No
PR	Ambulance; doctor office to residence	100%	No
PS	PET; pstv; nt ext isch-pstv ext ishcemia	100%	No

PX	Ambulance; doctor office to hosp w stop at doctor	100%	No
Q3	Live kidney donor surgery and related services	100%	No
Q4	Service for ordering/referring physician qualifies as a service exception	100%	No
Q7	One Class A finding	100%	No
Q8	Two Class B findings	100%	No
Q9	One Class B and two class C findings	100%	No
QA	FDA investigational device exemption	100%	No
QC	Single channel monitoring	100%	No
QD	Recording and storage in solid state memory by digital recorder	100%	No
QE	Prescribed amount of oxygen is less than one liter per minute	100%	No
QF	Prescribed amount of oxygen exceeds 4 liters per minute	100%	No
QG	Prescribed amount of oxygen is greater than four liters per minute	100%	No
QH	Oxygen conserving device is being used with an oxygen delivery system	100%	No
QL	Patient pronounced dead after ambulance called	100%	No

QM	Ambulance service provided under arrangement by provider of services	100%	No
QN	Ambulance service furnished directly by provider of service	100%	No
QP	Documentation on file showing that the lab tests ordered individually or ordered as a cpt recognized panel	100%	No
QS	Monitored Anesthesia Care	100%	No
QT	Recording and storage on tape by an analog tape recorder	100%	No
QV	Item/Service provided as routine care	100%	No
QW	CLIA waived test	100%	No
RC	Right coronary artery	100%	No
RD	Multiple Purpose Modifier	100%	No
RD	Ambulance; residence to diag or ther site	100%	No
RE	Ambulance; residence to nh	100%	No
RG	Residence to hospital-based dialysis facility	100%	No
RH	Residence to hospital	100%	No
RI	Residence to site of trans	100%	No
RJ	Residence to non hospital-based dialysis facility	100%	No

RN	Ambulance; residence to SNF	100%	No
RP	Residence to physician's office	100%	No
RR	Rental item	10%	No
RT	Right Side	100%	No
RX	Ambulance; residence to hospital w stop at doctor	100%	No
SA	Nurse practitioner rendering service in collaboration with a physician	100%	No
SB	Nurse midwife	100%	No
SC	Medically necessary service or supply	100%	No
SD	Scene of accident or acute event to diagnostic or therapeutic site	100%	No
SE	Scene of accident or acute event to residential,domiciliary,custodial facility	100%	No
SF	Second opinion ordered by a professional review organization	100%	No
SG	ASC facility	100%	No
SH	Multiple Purpose Modifier	100%	No
SI	Ambulance; scene of accident to site of trans	100%	No
SI	Scene of accident or acute event to site of transfer (airport or helicopter pad).	100%	No

SJ	Scene of accident or acute event to non hospital based dialysis clinic.	100%	No
SK	Member pf high-risk population	100%	No
SM	Second surgical opinion	100%	No
SN	Scene of accident or acute event to SNF	100%	No
SP	Multiple Purpose Modifier	100%	No
SP	Ambulance; accident/incident to doctors office	100%	No
SQ	Item ordered by home health	100%	No
SS	Multiple Purpose Modifier	100%	No
ST	Related to trauma or injury	100%	No
SU	Procedure performed in physician's office	100%	No
SW	Services provided by a certified diabetic educator	100%	No
SX	Ambulance; scene of accident to hospital w stop at doctor	100%	No
SY	Persons who are in close contact with members of high-risk population (use only with codes for immunization)	100%	No
T1	Left foot, second digit	100%	No
T2	Left foot; third digit	100%	No
T3	Left foot; fourth digit	100%	No
T4	Left foot; fifth digit	100%	No

T5	Right foot; Great toe	100%	No
T6	Right foot; Second digit	100%	No
T7	Right foot; third digit	100%	No
T8	Right foot; fourth digit	100%	No
T9	Right foot; fifth digit	100%	No
TA	Left foot, great toe	100%	No
TC	Technical Component	70%	No
TD	RN	100%	No
TE	LPN/LVN	100%	No
TF	Intermediate level of care	100%	No
TG	Complex/High level of care	100%	No
TH	Obstetrical treatment/services/ prenatal	100%	No
TJ	Program group; child and/or adolescent	100%	No
TL	Early intervention/individualized family services plan (IFSP)	100%	No
TM	Individualized education program (IEP)	100%	No
TN	Rural/Outside providers customary service area	100%	No
TP	Medical transport, unloaded vehicle	100%	No
TQ	Basic life support (BLS) transport by a volunteer ambulance provider	100%	No
TS	Follow up service	100%	No
TT	Individualized service provided to more than one patient in the same setting	100%	No

TU	Special payment rate; overtime	100%	No
TV	Special payment rate; holiday/weekends	100%	No
TW	Back up equipment	100%	No
U1	Medicaid level of care 1, as defined by each state	100%	No
U2	Medicaid level of care 2, as defined by each state	100%	No
U3	Medicaid level of care 3, as defined by each state	100%	No
U4	Medicaid level of care 4, as defined by each state	100%	No
U5	Medicaid level of care 5, as defined by each state	100%	No
U6	Medicaid level of care 6, as defined by each state	100%	No
U7	Medicaid level of care 7, as defined by each state	100%	No
U8	Medicaid level of care 8, as defined by each state	100%	No
U9	Medicaid level of care 9, as defined by each state	100%	No
UA	Medicaid level of care 10, as defined by each state	100%	No
UB	Medicaid level of care 11, as defined by each state	100%	No
UC	Medicaid level of care 12, as defined by each state	100%	No
UD	Medicaid level of care 13, as defined by each state	100%	No

UE	Used durable medical equipment	100%	No
UF	Services provided; morning	100%	No
UF	Services provided; afternoon	100%	No
UH	Services provided; evening	100%	No
UJ	Services provided; night	100%	No
UK	Svs on behalf client-collat	100%	No
UN	Two Patients Served	100%	No
UP	Three Patients Served	100%	No
UQ	Four Patients Served	100%	No
UR	Five Patients Served	100%	No
US	Six or More Patients Served	100%	No
VP	Aphakic patient	100%	No

B. Non-Covered Modifiers

21	Prolonged Service

Version History

Original Publish Date:	September 1, 2010
Revision Date (s):	
1/1/2011	Format changes, minor edits
9/1/2013	Format changes, minor edits
9/18/2013	Correction to non covered modifier table

EY	No Physician or Other Licensed Health Care provider order for this service
GC	This service has been performed in part by a resident under the direction of a teaching physician
GL	Medically Unnecessary upgrade provided by physician
HU	Funded by child welfare agency
HV	Funded by state addictions agency
HW	Funded by state mental health agency
HX	Funded by county/local agency
HY	Funded by juvenile justice agency
HZ	Funded by criminal justice agency
J1	Competitive acquisition prog no-pay submission for a prescription number
J2	Competitive acquisition prog restocking
J3	Competitive acquisition prog drug not available

JW	Drug amount discarded/not administered
MS	Six-Month maintenance and servicing fee
P6	Decl brain-dead pat organs to be removed
Q0	Investigational clinical service provided in a clinical research study that is in a approved clinical research study
Q1	Routine clinical service provided in a clinical research study that is in an approved clinical research study
Q2	CMS/ORD demonstration project procedure
Q5	Service furnished by locum tenens physician
Q6	Service furnished by substitute physician
QJ	Service/items provided to a prisoner or patient in state or local custody
QK	Medical direction of two, three or four concurrent anesthesia procedures
QR	Item/Service provided Medicare spec study
QX	CRNA service: with medical direction by physician

QY	Medical direction of one CRNA by anesthesiologist
QZ	CRNA service: without medical direction by physician
SL	State supplied vaccine
SV	Pharmaceuticals delivered to patient's home but not utilized
TK	Extra patient or passenger; non-ambulance
TR	School based individual education program (IEP) services provided outside the public school district

- ***Please refer to Neighborhood's provider website at http://www.nhpri.org for specific provisions by product line.***

- ***This guideline is not a guarantee of reimbursement. Plan coverage, eligibility and claim payment edit rules may apply.***

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