
Modifier Reference Guide

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This training material was developed by the Upstate Medicare Division (UMD) for providers who furnish services to Medicare beneficiaries in the upstate New York region. It has been prepared as a tool to assist providers who bill the Medicare program, but it is not a legal document. This information was current at the time that it was developed, however, the official Medicare program provisions are contained in the relevant laws, regulations, and rulings. These provisions and any updates can be found on the UMD Web site, www.umd.nycpic.com, or on the Centers for Medicare & Medicaid Services (CMS) Web site, www.cms.hhs.gov. The ultimate responsibility for correct claim submission lies with the provider.

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Modifier Reference Guide

A service or procedure can be further described by using 2-digit modifiers. The Modifier Reference Guide lists Level I (CPT-4), Level II (non-CPT-4 alpha numeric modifiers), and Category II (Performance Measure Exclusion Modifiers). Level I and II modifier definitions are contained in the Healthcare Common Procedure Coding System (HCPCS). These modifiers can be used interchangeably with any code level. Category II modifiers may only be billed with Category II codes. Category II codes are identified as a 5-character code in which the fifth place is the letter "F."

Modifier Categories

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

Pricing Modifiers

Pricing modifiers are considered part of the 7-digit procedure code by the Upstate Medicare Division (UMD) and are used to determine the reasonable charge or fee for a service.

°QK °TC °26

Statistical Modifiers that Affect Pricing

Statistical modifiers that affect pricing are appended to a procedure code and always cause the reasonable charge or fee for the code billed to be modified in the same way every time.

°AA	°AD	AH	AJ	AQ	AR
AS	CD	CE	CF	GM	°QX
°QY	QZ	SG	°UN	°UP	°UQ
°UR	°US	50	53	54	55
62	66	78	80	82	°90
99					

Statistical/Informational Modifiers

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

1P	2P	3P	AE	AF	AG
AK	AM	AT	BL	CB	CR

E1	E2	E3	E4	EA	EB
EC	ED	EE	EJ	EM	EP
F1	F2	F3	F4	F5	F6
F7	F8	F9	FA	FB	FC
FP	G1	G2	G3	G4	G5
G6	G7	G8	G9	GA	GC
GD	GE	GG	GH	GJ	GN
GO	GP	GQ	GR	GS	GT
GV	GW	GY	GZ	HE	°J1
J2	J3	JA	JB	JW	KO
KP	KQ	KX	LC	LD	LR
LS	LT	M2	P1	P2	P3
P4	P5	P6	Q0	Q1	Q3
Q4	Q5	Q6	Q7	Q8	Q9
QA	QC	QD	QL	QM	QN
QP	QR	QS	°QT	QV	°QW
RC	RD	RT	°SF	ST	SU
SW	SY	T1	T2	T3	T4
T5	T6	T7	T8	T9	TA
TN	TQ	TT	VP	21	22
23	24	25	32	47	51
52	56	57	58	59	73
74	76	77	79	91	

° Denotes modifiers which must be placed in the first modifier field.

Ranking Modifiers

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

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

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

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

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

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

Level I – CPT-4 Modifiers

- 21 Prolonged E&M Services:** When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management (E&M) service within a given category, it may be identified by adding modifier 21 to the E&M code number. A report may also be appropriate.
- 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 the additional work.
- 23 Unusual Anesthesia:** Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances, must be done under general anesthesia. This circumstance may

be reported by adding modifier 23 to the procedure code of the basic service.

- 24 Unrelated E&M Service by the Same Physician During a Postoperative Period:** The physician may need to indicate that an E&M service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E&M service.
- 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 and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E&M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E&M service to be reported. The E&M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting the E&M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E&M service. **Note:** This modifier is not used to report an E&M service that resulted in a decision to perform surgery. See modifier 57.
- 26 Professional Component:** Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier 26 to the usual procedure number. **Note:** The 26 modifier should not be appended to procedure codes that

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- represent a professional component (e.g., 93010 – Electrocardiogram; interpretation and report only).
- 32 Mandated Services:** Services related to mandated consultation and/or related services (e.g., third party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.
- 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.
- 50 Bilateral Procedure:** Unless otherwise identified in the listings, bilateral procedures that are performed in the same operative session should be identified by adding modifier 50 to the appropriate five digit code.
- 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 appending the modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated “add-on” codes.
- 52 Reduced Services:** Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician’s discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:**
- For outpatient hospital reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.
- 53 Discontinued Procedure:** Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. 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.
- 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.
- 55 Postoperative Management Only:** When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.
- 56 Preoperative Management Only:** When one physician performed the preoperative care and evaluation and another physician

- performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.
- 57 Decision for Surgery:** 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.
- 58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period:** It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned or anticipated (staged); b) more extensive than the original procedure; or c) 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 or procedure room (e.g., unanticipated clinical condition), see modifier 78.
- 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 that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances, should modifier 59 be used.
- 62 Two Surgeons:** When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding the 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 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 the modifier 80 or 82 added, as appropriate.
- 66 Surgical Team:** Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the “surgical team” concept. Such circumstances may be identified by each participating physician with the addition of the modifier 66 to the basic procedure number used for reporting services.
- 73 Discontinued Outpatient Hospital/ Ambulatory Surgical 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

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- procedure number and the addition of the modifier 73. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.
- 74 Discontinued Outpatient Hospital/Ambulatory Surgical 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.
- 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.
- 77 Repeat Procedure by Another Physician:** The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure or service.
- 78 Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative 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 or procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)
- 79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period:** The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)
- 80 Assistant Surgeon:** Surgical assistant services may be identified by adding the modifier 80 to the usual procedure number(s).
- 82 Assistant Surgeon (when qualified resident surgeon 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).
- 90 Reference (Outside) Laboratory:** 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.
- 91 Repeat Clinical Diagnostic Laboratory Test:** In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with

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specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

- 99 Multiple Modifiers:** Under certain circumstances more than four modifiers may be necessary to completely delineate a service. 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.

Level II – HCPCS Alpha Numeric Modifiers

- °AA** Anesthesia services performed personally by anesthesiologist.
- °AD** Medical supervision by a physician: more than four concurrent anesthesia procedures.
- AE** Registered dietician.
- AF** Specialty physician.
- AG** Primary physician.
- AH** Clinical psychologist (CP). [Used when a medical group employs a CP and bills for the CP's service.]
- AJ** Clinical social worker (CSW). [Used when a medical group employs a CSW and bills for the CSW's service.]
- AK** Nonparticipating physician.
- AM** Physician, team member service.
- AQ** Physician providing a service in an unlisted Health Professional Shortage Area (HPSA).
- AR** Physician provider services in a Physician Scarcity Area (PSA). (Effective for dates of service on or after January 1, 2005, to December 31, 2007.)
- AS** Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery.
- AT** Acute treatment. This modifier should be used when reporting a spinal manipulation service (codes 98940, 98941, and 98942).
- BL** Special acquisition of blood and blood products.
- 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.
- 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.
- 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.
- CF** AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable.
- CR** Catastrophe/Disaster related.
- E1** Upper left, eyelid.
- E2** Lower left, eyelid.
- E3** Upper right, eyelid.
- E4** Lower right, eyelid.
- EA** Erythropoetic Stimulating Agent (ESA) administered to treat anemia due to Anti-Cancer Chemotherapy.

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EB	Erythropoetic Stimulating Agent (ESA) administered to treat anemia due to Anti-Cancer Radiotherapy.	FB	Item provided without cost to provider, supplier or practitioner, or credit received for replaced device (examples, but not limited to covered under warranty, replaced due to defect, free samples).
EC	Erythropoetic Stimulating Agent (ESA) administered to treat anemia not due to Anti-Cancer Radiotherapy or Anti-Cancer Chemotherapy.	FC	Partial credit received for replaced parts.
ED	Hematocrit Level has exceeded 39% (or Hemoglobin level has exceeded 13.0 G/DL) for 3 or more consecutive billing cycles immediately prior to and including the current cycle.	FP	Service provided as part of family planning program.
EE	Hematocrit level has not exceeded 39% (or Hemoglobin level has not exceeded 13.0 G/DL) for 3 or more consecutive billing cycles immediately prior to and including the current cycle.	G1	Most recent urea reduction ratio (URR) reading of less than 60.
EJ	Subsequent claims for a defined course of therapy, e.g., EPO, sodium hyaluronate, infliximab.	G2	Most recent urea reduction ratio (URR) reading of 60 to 64.9.
EM	Emergency reserve supply (for ESRD benefit only).	G3	Most recent urea reduction ratio (URR) reading of 65 to 69.9.
EP	Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program.	G4	Most recent urea reduction ratio (URR) reading of 70 to 74.9.
F1	Left hand, second digit.	G5	Most recent urea reduction ratio (URR) reading of 75 or greater.
F2	Left hand, third digit.	G6	ESRD patient for whom less than six dialysis sessions have been provided in a month.
F3	Left hand, fourth digit.	G7	Pregnancy resulted from rape or incest or pregnancy certified by physician as life threatening.
F4	Left hand, fifth digit.	G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure.
F5	Right hand, thumb.	G9	Monitored anesthesia care (MAC) for patient who has history of severe cardio-pulmonary condition.
F6	Right hand, second digit.	GA	Waiver of liability statement on file. (Advance Beneficiary Notice (ABN).)
F7	Right hand, third digit.	GC	This service has been performed in part by a resident under the direction of a teaching physician.
F8	Right hand, fourth digit.		
F9	Right hand, fifth digit.		
FA	Left hand, thumb.		

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<p>GD Units of service exceeds Medically Unlikely Edit value and represents reasonable and necessary services.</p> <p>GE This service has been performed by a resident without the presence of a teaching physician under the primary care exception.</p> <p>GG Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day.</p> <p>GH Diagnostic mammogram converted from screening mammogram on same day.</p> <p>GJ Opt out physician or practitioner emergency or urgent service.</p> <p>GM Multiple patients on one ambulance trip.</p> <p>GN Services delivered under an outpatient speech language pathology plan of care.</p> <p>GO Services delivered under an outpatient occupational therapy plan of care.</p> <p>GP Services delivered under an outpatient physical therapy plan of care.</p> <p>GQ Via asynchronous telecommunications system.</p> <p>GR This service was performed in whole or in part by a resident in a department of veterans affairs medical center or clinic, supervised in accordance with VA policy.</p> <p>GS Dosage of EPO or darbepoetin alpha has been reduced and maintained in response to hematocrit or hemoglobin level.</p> <p>GT Via interactive audio and video telecommunication systems.</p> <p>GV Attending physician not employed or paid under arrangement by the patient's hospice provider.</p> <p>GW Service not related to the hospice patient's terminal condition.</p>	<p>GY Item or service statutorily excluded or does not meet the definition of any Medicare benefit.</p> <p>GZ Item or service expected to be denied as not reasonable and necessary.</p> <p>HE Mental health program.</p> <p>°J1 Competitive acquisition program (CAP), no-pay submission for a prescription number.</p> <p>J2 Competitive acquisition program (CAP), restocking of emergency drugs after emergency administration and a prescription number.</p> <p>J3 Competitive acquisition program (CAP), drug not available through CAP as written, reimbursed under average sales price (ASP) methodology.</p> <p>JA Administered intravenously.</p> <p>JB Administered subcutaneously.</p> <p>JW Drug amount discarded/not administered to any patient. The JW modifier must not be used on Medicare Part B drug CAP claims.</p> <p>KO Single drug unit dose formulation.</p> <p>KP First drug of a multiple drug unit dose formulation.</p> <p>KQ Second or subsequent drug of a multiple drug unit dose formulation.</p> <p>KX Therapy cap exception has been approved or it meets all the guidelines for an automatic exception. Specified required documentation on file.</p> <p>LC Left circumflex coronary artery.</p> <p>LD Left anterior descending coronary artery.</p> <p>LR Laboratory round trip.</p>
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LS	FDA-monitored intraocular lens implant.	Q7	One Class A finding.
LT	Left side (used to identify procedures performed on the left side of the body).	Q8	Two Class B findings.
M2	Medicare Secondary Payer (MSP). (Under certain circumstances, a participating CAP physician may procure a CAP drug from a source other than the CAP vendor because of a mistake in identifying the patient's primary insurer. Under these unusual circumstances, participating CAP physicians must use the M2 modifier to receive payment for the drug at the non-CAP rate.)	Q9	One Class B and Two Class C findings.
P1	A normal healthy patient.	QA	FDA investigational device exemption. Discontinued as of 12/31/07.
P2	A patient with mild systemic disease.	QC	Single channel monitoring.
P3	A patient with severe systemic disease.	QD	Recording and storage in solid state memory by digital recorder.
P4	A patient with severe systemic disease that is a constant threat to life.	°QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
P5	A moribund patient who is not expected to survive without the operation.	QL	Patient pronounced dead after ambulance called.
P6	A declared brain-dead patient whose organs are being removed for donor purposes.	QM	Ambulance service provided under arrangement by a provider of services.
Q0	Investigational clinical service provided in a clinical research study that is in an approved clinical research study. Effective for dates of service on and after 1/1/08.	QN	Ambulance service furnished directly by a provider of services.
Q1	Routine clinical service provided in a clinical research study that is in an approved clinical research study. Effective for dates of service on and after 1/1/08.	QP	Documentation is on file showing that the laboratory test(s) was ordered individually or ordered as a CPT-recognized panel other than automated profile codes 80002-80019, G0058, G0059, and G0060.
Q3	Live kidney donor and related services.	QR	Item or service provided in a Medicare specified study. Discontinued as of 12/31/07.
Q4	Service for ordering/referring physician qualifies as a service exemption.	QS	Monitored anesthesia care service.
Q5	Service furnished by a substitute physician under a reciprocal billing arrangement.	°QT	Recording and storage on a tape by an analog tape recorder.
Q6	Service furnished by a locum tenens physician.	QV	Item or service provided as routine care in a Medicare qualifying clinical trial. Discontinued as of 12/31/07.
		°QW	Clinical Laboratory Improvement Amendment (CLIA) waived test.
		°QX	CRNA service with medical direction by a physician.

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<p>°QY Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist.</p> <p>QZ CRNA service: without medical direction by a physician.</p> <p>RC Right coronary artery.</p> <p>RD Drug provided to beneficiary, but not administered incident to.</p> <p>RT Right side (used to identify procedures performed on the right side of the body).</p> <p>°SF Second opinion ordered by a Professional Review Organization (PRO) per Section 9401, P.L. 99-272 (100% reimbursement – no Medicare deductible or coinsurance).</p> <p>SG Ambulatory surgical center (ASC) facility service.</p> <p>ST Related to trauma or injury.</p> <p>SU Procedure performed in physician’s office (to denote use of facility and equipment).</p> <p>SW Services provided by a certified diabetic educator.</p> <p>SY Persons who are in close contact with member of high-risk population (use only with codes for immunization).</p> <p>T1 Left foot, second digit.</p> <p>T2 Left foot, third digit.</p> <p>T3 Left foot, fourth digit.</p> <p>T4 Left foot, fifth digit.</p> <p>T5 Right foot, great toe.</p> <p>T6 Right foot, second digit.</p> <p>T7 Right foot, third digit.</p> <p>T8 Right foot, fourth digit.</p>	<p>T9 Right foot, fifth digit.</p> <p>TA Left foot, great toe.</p> <p>°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. Note: The TC modifier should not be appended to procedure codes that represent the technical component (e.g., 93005 – Electrocardiogram; tracing only, without interpretation and report).</p> <p>TN Rural/outside providers’ customary service area.</p> <p>TQ Basic life support transport by a volunteer ambulance provider.</p> <p>TT Individualized service provided to more than one patient in same setting.</p> <p>°UN Two patients served.</p> <p>°UP Three patients served.</p> <p>°UQ Four patients served.</p> <p>°UR Five patients served.</p> <p>°US Six or more patients served.</p> <p>VP Aphakic patient.</p>
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Category II – Performance Measure Exclusion Modifiers

The following Category II modifiers may only be billed with Category II codes. Category II codes are identified as a five-character code in which the fifth place is the letter “F.”

<p>1P</p>	<p>Performance Measure Exclusion Modifier due to Medical Reasons Includes:</p>
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- not indicated (absence of organ/limb, already received/performed, other)	I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport.
- contraindicated (patient allergic history, potential adverse drug interaction, other)	J	Non-hospital based dialysis facility.
2P Performance Measure Exclusion Modifier due to Patient Reasons Includes:	N	Skilled nursing facility (SNF) (1819 facility).
- patient declined	P	Physician's office.
- economic, social, or religious reasons	R	Residence.
- other patient reasons	S	Scene of accident or acute event.
3P Performance Measure Exclusion Modifier due to System Reasons Includes:	X	(Destination code only) Intermediate stop at physician's office on the way to the hospital.
- resources to perform the services not available		
- insurance coverage/payor-related limitations		
- other reasons attributable to health care delivery system		

Ambulance Origin and Destination Modifiers

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

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

D	Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes.	
E	Residential, domiciliary, custodial facility (other than an 1819 facility).	
G	Hospital based dialysis facility (hospital or hospital related).	
H	Hospital.	

Resources

For more detailed information about modifiers, see:

- Current Procedural Terminology (CPT) Manual.
- Healthcare Common Procedure Coding System (HCPCS) Manual.
- Medicare Learning Network (MLN) Matters Articles and Change Requests, available at www.cms.hhs.gov/MLNMattersArticles/:
 - MM4064 – MMA – Competitive Acquisition Program (CAP) for Part B Drugs – Coding, Testing, and Implementation.
 - SE0703 – Assignment of Dedicated Medicare Secondary Payer Modifier Introduced in Change Request (CR) 5332 (Transmittal 1088).
 - CR 5775 - 2008 Healthcare Common Procedure Coding System (HCPCS) Annual Update (Transmittal 1370).
 - CR 5923 – Additional Clarification to Chapter 17, Section 40, Regarding Processing of Drug Claims with the JW Modifier (Transmittal 1478CP).