



Appendix E: Modifiers that affect payment



Note: Only modifiers that affect payment are listed in this Appendix. Refer to current CPT[®] and HCPCS books for a complete list of modifiers, with their descriptions and instructions.

▶ CPT[®] code modifiers

–22 Unusual services

Procedures with this modifier may be individually reviewed prior to payment. A report is required for this review. Payment varies based on the report submitted.

–24 Unrelated evaluation and management (E/M) services by the same physician during a postoperative period

Used to indicate an evaluation and management service unrelated to the surgical procedure was performed during a postoperative period. *Documentation must be submitted with the billing form when this modifier is used.* Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less.

–25 Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure

Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

–26 Professional component

Certain procedures are a combination of the professional (–26) and technical (–TC) components. This modifier should be used when only the professional component is performed. When a global service is performed, neither the –26 nor the –TC modifier should be used. (See above for information on the use of the –TC modifier.)

–47 Anesthesia by surgeon

–50 Bilateral surgery

The bilateral modifier identifies cases where a procedure typically performed on one side of the body is, in fact, performed on both sides of the body. Payment is made at one hundred fifty percent of the global surgery fee for the procedure. Providers must bill using two line items on the bill form. The modifier –50 should be applied to the second line item.

–51 Multiple surgeries

For procedure codes that represent multiple surgical procedures, payment is made based on the fee schedule allowance associated with that code. Refer to the global surgery rules for additional information.

–52 Reduced services

Payment is made at the fee schedule level or billed charge, whichever is less.

–53 Discontinued services

CMS has established reduced RVUs for CPT® code **45378** when billed with **modifier –53**. L&I prices this code-modifier combination according to those RVUs.

–54 Surgical care only (see Note, below)

When one physician performs a surgical procedure and another provides preoperative and/or postoperative management.

–55 Postoperative management only (see Note, below)

When one physician performs the postoperative management and another physician has performed the surgical procedure.

–56 Preoperative management only (see Note, below)

When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure.



Note: When providing less than the global surgical package, providers should use modifiers –54, –55, and –56. These modifiers are designed to ensure that the sum of all allowances for all providers doesn't exceed the total allowance for the global surgery period. These modifiers allow direct payment to the provider of each portion of the global surgery services.

–57 Decision for surgery

Used only when the decision for surgery was made during the preoperative period of a surgical procedure with a global surgery follow up period. It should not be used with visits furnished during the global period of minor procedures (0-10 day global period) unless the purpose of the visit is a decision for major surgery. Separate payment should be made even if the visit falls within the global surgery period. No separate documentation is needed when submitting a billing form with this modifier.

–58 Staged or related procedure or service by the same physician during the postoperative period

Used to report a surgical procedure that is staged or related to the primary surgical procedure and is performed during the global period.

–62 Two surgeons

For surgery requiring the skills of two surgeons (usually with a different specialty), each surgeon is paid at 62.5% of the global surgical fee. No payment is made for an assistant-at-surgery in these cases. Both surgeons must submit separate operative reports describing their specific roles.

–66 Team surgery

Used when highly complex procedures are carried out by a surgical team. This may include the concomitant services of several physicians, often of different specialties, other highly skilled, specially trained personnel, and various types of complex equipment. Procedures with this modifier are reviewed and priced on an individual basis. Each surgeon must submit separate operative reports describing their specific roles.

–73 Discontinued procedures prior to the administration of anesthesia

Modifier –73 is used when a physician cancels a surgical procedure due to the onset of medical complications subsequent to the patient's preparation, but prior to the administration of anesthesia. Payment will be at **50%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

–74 Discontinued procedures after administration of anesthesia

Modifier –74 is used when a physician terminates a surgical procedure due to the onset of medical complications after the administration of anesthesia or after the procedure was started. Payment will be at **100%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

–78 Return to the operating room for a related procedure during the postoperative period

Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

–79 Unrelated procedure or service by the same physician during the postoperative period

Use of this modifier allows separate payment for procedures not associated with the original surgery. Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

–80 Assistant surgeon (see below)**–81 Minimum assistant surgeon (see below)****–82 Assistant surgeon (when qualified resident surgeon not available)**

Assistant surgeon modifiers. Physicians who assist the primary physician in surgery should use **modifiers –80, –81, or –82** depending on the medical necessity. Payment for procedures with these modifiers is made at the billed charge or twenty

percent of the global surgery amount for the procedure, whichever is less. Refer to the assistant surgeon indicator in the Professional Services Fee Schedule to determine if assistant surgeon fees are payable.

–91 Repeat clinical diagnostic laboratory test performed on the same day to obtain subsequent reportable test values(s) (separate specimens taken in separate encounters)

Payment will be made for repeat test(s) performed for the same patient on the same day when specimen(s) have been taken from separate encounters. Test(s) normally performed as a series, e.g. glucose tolerance test don't qualify as separate encounters. The medical necessity for repeating the test(s) must be documented in the patient record.

–99 Multiple modifiers

This modifier should only be used when two or more modifiers affect payment.

Payment is based on the policy associated with each individual modifier that describes the services performed. For billing purposes, only **modifier –99** should go in the modifier column, with the individual descriptive modifiers that affect payment listed elsewhere on the billing form.

▶ **HCPSC code modifiers**

–AA Anesthesia services performed personally by anesthesiologist

–E1 Upper left eyelid

–GM Multiple patients on one ambulance trip

–GT Interactive telecommunication

Teleconsultations via interactive audio and video telecommunication systems.



Link: Payment policies for teleconsultations are located in [Chapter 10: Evaluation and Management \(E/M\) Services](#).

–LT Left side

Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

–NU New purchased DME

Use the **–NU** modifier when a new DME item is to be purchased.

–P1 A normal healthy patient

–P2 A patient with mild systemic disease

- P3 A patient with severe systemic disease**
- P4 A patient with severe systemic disease that is a constant threat to life**
- P5 A moribund patient who is not expected to survive without the operation**
- P6 A declared brain-dead patient whose organs are being removed for donor purposes**
- QK Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals**
- QX CRNA service: with medical direction by a physician**
- QY Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist**
- QZ CRNA service: without medical direction by a physician**
- RR Rented DME**

Use the **–RR** modifier when DME is to be rented.
- RT Right side**

Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.
- SG Ambulatory surgical center (ASC) facility service**

Bill the appropriate CPT® surgical code(s) adding this **modifier –SG** to each surgery code.
- SU Procedure performed in physician's office**

Denotes the use of facility and equipment while performing a procedure in a provider's office.
- TC Technical component**

Certain procedures are a combination of the professional (**–26**) and technical (**–TC**) components. This modifier should be used when only the technical component is performed. When a global service is performed, neither the **–26** nor the **–TC** modifier should be used. (See above for information on the use of the **–26** modifier.)
- UN Two patients served**
- UP Three patients served**
- UQ Four patients served**
- UR Five patients served**
- US Six or more patients served**

▶ Local code modifiers**–1S Surgical dressings for home use**

Bill the appropriate HCPCS code for each dressing item using this **modifier –1S** for each item. Use this modifier to bill for surgical dressing supplies dispensed for home use.

–3R Billing for advanced imaging procedures

This code is billed by gold card providers when billing advanced imaging procedures subject to utilization review.

–7N X-rays and laboratory services in conjunction with an IME

When X-rays, laboratory, and other diagnostic tests are provided with an exam, identify the service(s) by adding the **modifier – 7N** to the usual procedure number.

–8R COHE modifier for case management codes and consultations

Identifies when COHEs bill for these codes and adjusts payments.

–8S COHE modifier for health services coordinators (HSCs)

This modifier allows HSCs to bill for some services more than once per day.



Link: Procedure codes are listed in the L&I Professional Services Fee Schedules, Radiology and Laboratory Sections, available at <http://feeschedules.Lni.wa.gov>.