Modifiers List in Medical Billing 2023

October 28, 2023 by NSingh (MBA, RCM Expert)

List of Modifiers in Medical Billing is a very important document and everyone who is working in the medical billing process should have the basic knowledge of these CPT Modifiers List. We also called it CPT modifiers here CPT stands for **Current Procedural Terminology**.

Modifier definition in medical billing

> ***CPT Modifiers are codes that are used to "Enhance or Alter The Description of service or Supply in Certain Condition".***
>
> *Definition of Modifier in Medical Billing*

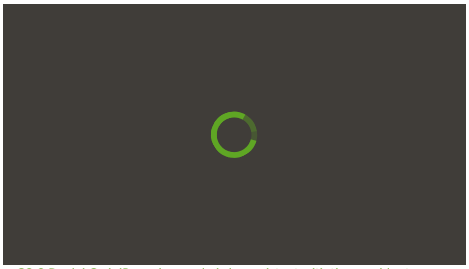
Table of Contents +

What is Modifiers in Medical Billing and Coding?

A **CPT Modifier** is a two-position alpha and alpha-numeric code used to identify certain situations that require the basic value of a procedure to be either enhanced or diminished. A modifier provides the means by which a service or procedure that has been performed can be altered without changing the procedures code. Modifying circumstances include. CPT Modifiers are an important part of the managed care system or medical billing.

1. A service or procedure that has both a professional and technical component. **(26 or TC)**
2. A service or procedure that was performed more than once on the same day by the same physician or by a different physician. **(76 or 77)**
3. A bilateral procedure service that was performed. **(50)**
4. A distinct procedure service. **(59)**

Type of Modifiers in Medical Billing:



CO 8 Denial Code|Procedure code is inconsistent with the provider type

There are two types of modifiers **A)** Level 1 Modifier and **B)** Level 2 Modifier.

A- Level 1 modifiers are CPT modifiers containing 2 numeric digits. These modifiers administered by the American Medical Association.

B- HCPCS modifiers are called level 2 modifiers. It contains alpha or alphanumeric digits.

CPT Modifiers list in Medical Billing:

There are different types of modifiers listed in medical billing and they are specified as per their uses like Anesthesia modifier, bilateral modifier, surgery modifier, etc. Description is mention below

1. Anesthesia Modifiers in Medical Billing –

These type of modifiers used with anesthesia procedure or CPT codes **(00100- 01999)**

Note- Anesthesia Services Billed by Anesthesiologist (Do not use when the provider of service is Certified Registered Nurse Anesthetist-CRNA)

Modifier AA -modifier used when service performed personally by an anesthesiologist.

Modifier QY- Medical direction by one CRNA by an anesthesiologist

Modifier QK- Medical direction of 2, 3, or 4 concurrent anesthesia procedures

Modifier AD– Medical supervision by a physician, more than four services is an anesthesiologist.

Modifier QS- Monitored Anesthesia Care(MAC)

2. Anesthesia Physical Status Modifiers:

These modifiers are informational purposes only.

Modifier P1- A normal healthy patient.

Modifier P2- A patient with mild systemic disease.

Modifier P3– A patient with severe systemic disease.

Modifier P4– A patient with severe systemic disease that is a constant threat of life.

Modifier P5 – A dying state patient who is not expected to survive without operation.

Modifier P6– A declared brain dead patient whose organs being removed for donor purposes

Modifier G8– Monitored anesthesia care for deep complex, complicated, or markedly surgical procedures.

Modifier G9- Monitor anesthesia care for patient who has history of the severe cardiopulmonary condition.

3. List of Modifiers for Assistant Surgeon:

Medicare will make payment for an assistant at the surgery when the procedure is covered for an assistant and one of the following situations exists.

Modifier 80– Assistant Surgeon

Modifier 81– Minimum Assistant surgeon

Modifier 82– Assistant surgeon when qualified surgeon not present.

Modifier AS– Physician Assistant (PA), Clinical Nurse Specialist(CNS), Nurse Practioner (NP) for assistant surgery.

The allowed amount for assistant at surgery is 16% of physician fee schedule. For PA, CNS and NP allowed amount is 85% of 16% of physician fee schedule.

4. Bilateral Modifier:

Modifier 50– Bilateral means procedure performed in both sides RHS and LHS. Modifier 50 is used for bilateral procedures.

5. Evaluation And Management(E/M) Modifiers

The CPT Modifiers used with E/M codes are called E/M modifiers. E/M procedure codes range is **99201- 99499**.

AI– Principle physician of record. Effective from 01 January 2010. AI modifier is used by admitting or attending physician who oversees patient care. The principal physician of record shall append this modifier in addition to the initial visit code.

Modifier 24 Description– Unrelated E/M services by the same physician during the postoperative period.

Modifier 25 definition– Distinctive procedure.Significant, separately, identifiable E/M service by the same physician on the same day of the procedure.

Modifier 57– Decision of surgery. An E/M service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to appropriate level of E/M service.

6. National Correct Coding Initiative(NCCI)

Modifier 59- As per the **National Correct Coding Initiative(NCCI)** CPT modifier 59 is distinct Procedure service. This modifier is used to indicate that the service updated with modifier 59 is distinct from other services performed on the same day.

Appropriate circumstances for using modifier 59-

1. A different session or patient encounter.
2. Different procedure or surgery
3. Different site or organ system
4. Separate incision/excision
5. Separate lesion
6. Separate injury

7. Modifiers for Repeat procedures:

Modifier 76– Repeat procedure or service by the same physician or other qualified healthcare professional. It may be necessary to indicate that procedure or service was repeated by the same physician or other qualified health professional subsequent to the original procedure or service.

Modifier 77- Repeat procedure by another physician or other qualified health care professional. It may be necessary to indicate that basic procedure or service was repeated by another physician or other qualified healthcare professional subsequent to the original procedure or service.

8. List of Surgical Modifiers

Modifier 51– When multiple procedures, other than E/M services, physical medicine, and rehabilitation services or provision of supplies are performed at the same time by the same provider. The additional services other than primary procedure are appended by modifier 51.

Modifier 52- Reduced services. Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's direction. Medicare requires and operative report for surgical procedures and s concise statement as to how the reduced service is different from standard procedure. Claims for non surgical services reported with modifier 52 must contain a statement as to how the reduce service is different from standard service.

Modifier 53- Discontinued procedure. Under certain circumstances the physician may elect to terminate a surgical or diagnostic procedure. An operative report is required as well as a statement as to how much of the original procedure was accomplished.

Modifier 58- Staged or related procedure or service by the same physician during the postoperative period. It is necessary to indicate that postoperative period was

- Planned or Staged
- More extensive than original procedure
- For therapy following a surgical procedure.

Modifier 62- WhenTwo surgeons involved in the procedure. When 2 surgeons work together as primary surgeons performing distinct parts of procedure, each surgeon should report the distinct operative work adding the modifier 62 to the procedure code and any associated add on code for that procedures as long as both surgeons continue to work together primary surgeon.

Modifier 66- Whenservices perform by surgical team.Under some circumstances, highly complex procedures are carried out under the "surgical team". Such circumstances may be identified by each participating provider with the addition of modifier 66 to the basic procedure used for reporting services. In this case medicare requires operative report as well.

Modifier 78- Unplanned return to operating room by same physician or other qualified professional for related procedure during postoperative period. It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure.

Modifier 79– Unrelated procedure or service by the same physician during the postoperative period. The physician may need to indicate that the perform procedure during the postoperative period was unrelated to the original procedure.

List of HCPCS Modifiers A to Z (2023)

HCPCS is a short form of **"Healthcare Common Procedural Coding System (HCPCS)"**.

HCPCS Modifiers	Modifiers Description
A1	Dressing for 1 wound
A2	Dressing for 2 wounds
A3	Dressing for 3 wounds
A4	Dressing for 4 wounds
A5	Dressing for 5 wounds
A6	Dressing for 6 wounds
A7	Dressing for 7 wounds
A8	Dressing for 8 wounds
A9	Dressing for 9 or more wounds
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
AI	Principal physician of record
AJ	Clinical social worker
AK	Non participating physician
AM	Physician, team member service
AO	Alternate payment method declined by provider of service
AP	Determination of refractive state was not performed in the course of diagnostic ophthalmological examination
AQ	Physician providing a service in an unlisted health professional shortage area (hpsa)
AR	Physician provider services in a physician scarcity area
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
AT	Acute treatment (this modifier should be used when reporting service 98940, 98941, 98942, It is for Date of service on or after October 12, 2007. This modifier requires on all claims for tetanus and rabies)
AU	Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
AV	Item furnished in conjunction with a prosthetic device, prosthetic or orthotic
AW	Item furnished in conjunction with a surgical dressing
AX	Item furnished in conjunction with dialysis services
AY	Item or service furnished to an esrd patient that is not for the treatment of esrd
AZ	Physician providing a service in a dental health professional shortage area for the purpose of an electronic health record incentive payment
B	
BA	Item furnished in conjunction with parenteral enteral nutrition (pen) services
BL	Special acquisition of blood and blood products
BO	Orally administered nutrition, not by feeding tube
BP	The beneficiary has been informed of the purchase and rental options and has elected to purchase the item
BR	The beneficiary has been informed of the purchase and rental options and has elected to rent the item
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
C	
CA	Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission
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
CC	Procedure code change (use 'cc' when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed)
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
CG	Policy criteria applied
CH	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted
CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
CP	Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification (c-apc) procedure, but reported on a different claim ((Terminated on 12/31/2017)
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
CR	Catastrophe/disaster related
CS	Cost-sharing waived for specified covid-19 testing-related services that result in and order for or administration of a covid-19 test and/or used for cost-sharing waived preventive services furnished via telehealth in rural health clinics and federally qualified health centers during the covid-19 public health emergency
CT	Computed tomography services furnished using equipment that does not meet each of the attributes of the national electrical manufacturers association (nema) xr-29-2013 standard
E	
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
EB	Erythropoetic stimulating agent (esa) administered to treat anemia due to anti-cancer radiotherapy
EC	Erythropoetic stimulating agent (esa) administered to treat anemia not due to anti-cancer radiotherapy or anti-cancer chemotherapy
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
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
EJ	Subsequent claims for a defined course of therapy, e.g., epo, sodium hyaluronate, infliximab
EM	Emergency reserve supply (for esrd benefit only)
EP	Service provided as part of medicaid early periodic screening diagnosis and treatment (epsdt) program
ER	Items and services furnished by a provider-based, off-campus emergency department
ET	Emergency services
EX	Expatriate beneficiary
EY	No physician or other licensed health care provider order for this item or service
F	
F1	Left hand, 2nd digit
F2	Left hand, 3rd digit
F3	Left hand, 4th digit
F4	Left hand, 5th digit
F5	Right hand, thumb
F6	Right hand, 2nd digit
F7	Right hand, 3rd digit
F8	Right hand, 4th digit
F9	Right hand, 5th digit
FA	Left hand, thumb
FB	Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples)
FC	Partial credit received for replaced device

FP	Service provided as part of family planning program
FX	X-ray taken using film
FY	X-ray taken using computed radiography technology/cassette-based imaging
G	
G0	Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke
G1	Most recent urr reading of less than 60
G2	Most recent urr reading of 60 to 64.9
G3	Most recent urr reading of 65 to 69.9
G4	Most recent urr reading of 70 to 74.9
G5	Most recent urr reading of 75 or greater
G6	Esrd patient for whom less than six dialysis sessions have been provided in a month
G7	Pregnancy resulted from rape or incest or pregnancy certified by physician as life threatening
G8	Monitored anesthesia care (mac) for deep complex, complicated, or markedly invasive surgical procedure
G9	Monitored anesthesia care for patient who has history of severe cardio-pulmonary condition
GA	Waiver of liability statement issued as required by payer policy, individual case
GB	Claim being re-submitted for payment because it is no longer covered under a global payment demonstration
GC	This service has been performed in part by a resident under the direction of a teaching physician
GD	Units of service exceeds medically unlikely edit value and represents reasonable and necessary services (Terminated on 12/31/2019)
GE	This service has been performed by a resident without the presence of a teaching physician under the primary care exception
GF	Non-physician (Ex. nurse practitioner (np), certified registered nurse anesthetist (crna), certified registered nurse (crn), clinical nurse specialist (cns), physician assistant (pa)) services in a critical access hospital
GG	Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day
GH	Diagnostic mammogram converted from screening mammogram on same day
GJ	“opt out” physician or practitioner emergency or urgent service
GK	Reasonable and necessary item/service associated with a ga or gz modifier
GL	Medically unnecessary upgrade provided instead of non-upgraded item, no charge, no advance beneficiary notice (abn)
GM	Multiple patients on one ambulance trip
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
GQ	Via asynchronous telecommunications system
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
GS	Dosage of erythropoietin stimulating agent has been reduced and maintained in response to hematocrit or hemoglobin level
GT	Via interactive audio and video telecommunication systems
GU	Waiver of liability statement issued as required by payer policy, routine notice
GV	Attending physician not employed or paid under arrangement by the patient’s hospice provider
GW	Service not related to the hospice patient’s terminal condition
GX	Notice of liability issued, voluntary under payer policy
GY	Item or service statutorily excluded, does not meet the definition of any medicare benefit or, for non-medicare insurers, is not a contract benefit
GZ	Item or service expected to be denied as not reasonable and necessary
H	
H9	Court-ordered
HA	Child/adolescent program
HB	Adult program, non geriatric
HC	Adult program, geriatric
HD	Pregnant/parenting women’s program
HE	Mental health program
HF	Substance abuse program
HG	Opioid addiction treatment program
HH	Integrated mental health/substance abuse program
HI	Integrated mental health and intellectual disability/developmental disabilities program
HJ	Employee assistance program
HK	Specialized mental health programs for high-risk populations
HL	Intern
HM	Less than bachelor degree level
HN	Bachelors degree level
HO	Masters degree level

HP	Doctoral level
HQ	Group setting
HR	Family/couple with client present
HS	Family/couple without client present
HT	Multi-disciplinary team
HU	Funded by child welfare agency
HV	Funded 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
J	
J1	Competitive acquisition program no-pay submission for a prescription number
J2	Competitive acquisition program, restocking of emergency drugs after emergency administration
J3	Competitive acquisition program (cap), drug not available through cap as written, reimbursed under average sales price methodology
J4	Dmepos item subject to dmepos competitive bidding program that is furnished by a hospital upon discharge
J5	Off-the-shelf orthotic subject to dmepos competitive bidding program that is furnished as part of a physical therapist or occupational therapist professional service
JA	Administered intravenously
JB	Administered subcutaneously
JC	Skin substitute used as a graft
JD	Skin substitute not used as a graft
JE	Administered via dialysate
JF	Compounded drug Terminated on 06/30/2015
JG	Drug or biological acquired with 340b drug pricing program discount
JW	Drug amount discarded/not administered to any patient
K	
K0	Lower extremity prosthesis functional level 0 – does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.
K1	Lower extremity prosthesis functional level 1 – has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. typical of the limited and unlimited household ambulator.
K2	Lower extremity prosthesis functional level 2 – has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. typical of the limited community ambulator.
K3	Lower extremity prosthesis functional level 3 – has the ability or potential for ambulation with variable cadence. typical of the community ambulator who has the ability to transverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
K4	Lower extremity prosthesis functional level 4 – has the ability or potential for prosthetic ambulation that exceeds the basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete.
KA	Add on option/accessory for wheelchair
KB	Beneficiary requested upgrade for abn, more than 4 modifiers identified on claim
KC	Replacement of special power wheelchair interface
KD	Drug or biological infused through dme
KE	Bid under round one of the dmepos competitive bidding program for use with non-competitive bid base equipment
KF	Item designated by fda as class iii device
KG	Dmepos item subject to dmepos competitive bidding program number 1
KH	Dmepos item, initial claim, purchase or first month rental
KI	Dmepos item, second or third month rental
KJ	Dmepos item, parenteral enteral nutrition (pen) pump or capped rental, months four to fifteen
KK	Dmepos item subject to dmepos competitive bidding program number 2
KL	Dmepos item delivered via mail
KM	Replacement of facial prosthesis including new impression/moulage
KN	Replacement of facial prosthesis using previous master model
KO	Single drug unit dose formulation
KP	First drug of a multiple drug unit dose formulation
KQ	Second or subsequent drug of a multiple drug unit dose formulation
KR	Rental item, billing for partial month
KS	Glucose monitor supply for diabetic beneficiary not treated with insulin
KT	Beneficiary resides in a competitive bidding area and travels outside that competitive bidding area and receives a competitive bid item
KU	Dmepos item subject to dmepos competitive bidding program number 3
KV	Dmepos item subject to dmepos competitive bidding program that is furnished as part of a professional service
KW	Dmepos item subject to dmepos competitive bidding program number 4

KX	Requirements specified in the medical policy have been met
KY	Dmepos item subject to dmepos competitive bidding program number 5
KZ	New coverage not implemented by managed care
L	
L1	Provider attestation that the hospital laboratory test(s) is not packaged under the hospital opps (Terminated on 21/31/2016)
LC	Left circumflex coronary artery
LD	Left anterior descending coronary artery
LL	Lease/rental (use the 'll' modifier when dme equipment rental is to be applied against the purchase price)
LM	Left main coronary artery
LR	Laboratory round trip
LS	Fda-monitored intraocular lens implant
LT	Left side (used to identify procedures performed on the left side of the body)
M	
M2	Medicare secondary payer (msp)
MA	Ordering professional is not required to consult a clinical decision support mechanism due to service being rendered to a patient with a suspected or confirmed emergency medical condition
MB	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of insufficient internet access
MC	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of electronic health record or clinical decision support mechanism vendor issues
MD	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of extreme and uncontrollable circumstances
ME	The order for this service adheres to appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional
MF	The order for this service does not adhere to the appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional
MG	The order for this service does not have applicable appropriate use criteria in the qualified clinical decision support mechanism consulted by the ordering professional
MH	Unknown if ordering professional consulted a clinical decision support mechanism for this service, related information was not provided to the furnishing professional or provider
MS	Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty
N	
NB	Nebulizer system, any type, fda-cleared for use with specific drug
NR	New when rented (use the 'nr' modifier when dme which was new at the time of rental is subsequently purchased)
NU	New equipment
P	
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
PA	Surgical or other invasive procedure on wrong body part
PB	Surgical or other invasive procedure on wrong patient
PC	Wrong surgery or other invasive procedure on patient
PD	Diagnostic or related non diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days
PI	Positron emission tomography (pet) or pet/computed tomography (ct) to inform the initial treatment strategy of tumors that are biopsy proven or strongly suspected of being cancerous based on other diagnostic testing
PL	Progressive addition lenses
PM	Post mortem
PN	Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital
PO	Excepted service provided at an off-campus, outpatient, provider-based department of a hospital
PS	Positron emission tomography (pet) or pet/computed tomography (ct) to inform the subsequent treatment strategy of cancerous tumors when the beneficiary's treating physician determines that the pet study is needed to inform subsequent anti-tumor strategy
PT	Colorectal cancer screening test; converted to diagnostic test or other procedure
Q	
Q0	Investigational clinical service provided in a clinical research study that is in an approved clinical research study
Q1	Routine clinical service provided in a clinical research study that is in an approved clinical research study
Q2	Demonstration procedure/service
Q3	Live kidney donor surgery and related services
Q4	Service for ordering/referring physician qualifies as a service exemption

Q5	Service furnished under a reciprocal billing arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area
Q6	Service furnished under a fee-for-time compensation arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area
Q7	One class a finding
Q8	Two class b findings
Q9	One class b and two class c findings
QA	Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is less than 1 liter per minute (lpm)
QB	Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts exceeds 4 liters per minute (lpm) and portable oxygen is prescribed
QC	Single channel monitoring
QD	Recording and storage in solid state memory by a digital recorder
QE	Prescribed amount of stationary oxygen while at rest is less than 1 liter per minute (lpm)
QF	Prescribed amount of stationary oxygen while at rest exceeds 4 liters per minute (lpm) and portable oxygen is prescribed
QG	Prescribed amount of stationary oxygen while at rest is greater than 4 liters per minute (lpm)
QH	Oxygen conserving device is being used with an oxygen delivery system
QJ	Services/items provided to a prisoner or patient in state or local custody, however the state or local government, as applicable, meets the requirements in 42 cfr 411.4 (b)
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QL	Patient pronounced dead after ambulance called
QM	Ambulance service provided under arrangement by a provider of services
QN	Ambulance service furnished directly by a provider of services
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.
QQ	Ordering professional consulted a qualified clinical decision support mechanism for this service and the related data was provided to the furnishing professional
QR	Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is greater than 4 liters per minute (lpm)
QS	Monitored anesthesia care service
QT	Recording and storage on tape by an analog tape recorder
QW	Clia waived test
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
R	
RA	Replacement of a dme, orthotic or prosthetic item
RB	Replacement of a part of a dme, orthotic or prosthetic item furnished as part of a repair
RC	Right coronary artery
RD	Drug provided to beneficiary, but not administered “incident-to”
RE	Furnished in full compliance with fda-mandated risk evaluation and mitigation strategy (rems)
RI	Ramus intermedius coronary artery
RR	Rental (use the ‘rr’ modifier when dme is to be rented)
RT	Right side (used to identify procedures performed on the right side of the body)
S	
SA	Nurse practitioner rendering service in collaboration with a physician
SB	Nurse midwife
SC	Medically necessary service or supply
SD	Services provided by registered nurse with specialized, highly technical home infusion training
SE	State and/or federally-funded programs/services
SF	Second opinion ordered by a professional review organization (pro) per section 9401, p.l. 99-272 (100% reimbursement – no medicare deductible or coinsurance)
SG	Ambulatory surgical center (asc) facility service
SH	Second concurrently administered infusion therapy
SJ	Third or more concurrently administered infusion therapy
SK	Member of high risk population (use only with codes for immunization)
SL	State supplied vaccine
SM	Second surgical opinion
SN	Third surgical opinion
SQ	Item ordered by home health
SS	Home infusion services provided in the infusion suite of the iv therapy provider
ST	Related to trauma or injury
SU	Procedure performed in physician’s office (to denote use of facility and equipment)

SV	Pharmaceuticals delivered to patient’s home but not utilized
SW	Services provided by a certified diabetic educator
SY	Persons who are in close contact with member of high-risk population (use only with codes for immunization)
SZ	Habilitative services (Terminated on 12/31/2017)
	.
T	
T1	Left foot, 2nd digit
T2	Left foot,3rd digit
T3	Left foot,4th digit
T4	Left foot, 5th digit
T5	Right foot, great toe
T6	Right foot, 2nd digit
T7	Right foot, 3rd digit
T8	Right foot, 4th digit
T9	Right foot, 5th digit
TA	Left foot, great toe
TB	Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes
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.
TD	Rn
TE	Lpn/lvn
TF	Intermediate level of care
TG	Complex/high tech level of care
TH	Obstetrical treatment/services, prenatal or postpartum
TJ	Program group, child and/or adolescent
TK	Extra patient or passenger, non-ambulance
TL	Early intervention/individualized family service plan (ifsp)
TM	Individualized education program (iep)
TN	Rural/outside providers’ customary service area
TP	Medical transport, unloaded vehicle
TQ	Basic life support transport by a volunteer ambulance provider
TR	School-based individualized education program (iep) services provided outside the public school district responsible for the student
TS	Follow-up service
TT	Individualized service provided to more than one patient in same setting
TU	Special payment rate, overtime
TV	Special payment rates, holidays/weekends
TW	Back-up equipment
U	
U1	Medicaid level of care 1,As per every state guidelines and definition
U2	Medicaid level of care 2,As per every state guidelines and definition
U3	Medicaid level of care 3,As per every state guidelines and definition
U4	Medicaid level of care 4,As per every state guidelines and definition
U5	Medicaid level of care 5,As per every state guidelines and definition
U6	Medicaid level of care 6,As per every state guidelines and definition
U7	Medicaid level of care 7,As per every state guidelines and definition
U8	Medicaid level of care 8,As per every state guidelines and definition
U9	Medicaid level of care 9,As per every state guidelines and definition
UA	Medicaid level of care 10,As per every state guidelines and definition
UB	Medicaid level of care 11,As per every state guidelines and definition
UC	Medicaid level of care 12,As per every state guidelines and definition
UD	Medicaid level of care 13,As per every state guidelines and definition
UE	Used durable medical equipment
UF	Services provided in the morning
UG	Services provided in the afternoon
UH	Services provided in the evening
UJ	Services provided at night
UK	Services provided on behalf of the client to someone other than the client (collateral relationship)
UN	Two patients served
UP	Three patients served

UQ	Four patients served
UR	Five patients served
US	Six or more patients served
V	
V1	Demonstration modifier 1
V2	Demonstration modifier 2
V3	Demonstration modifier 3
V4	Demonstration modifier 4
V5	Vascular catheter (alone or with any other vascular access)
V6	Arteriovenous graft (or other vascular access not including a vascular catheter)
V7	Arteriovenous fistula only (in use with two needles)
V8	Infection present (This modifier Terminated on March 31, 2012)
V9	No infection present (This modifier Terminated on March 31, 2012)
VM	Medicare diabetes prevention program (mdpp) virtual make-up session
VP	Aphakic patient
X	
X1	Continuous/broad services: for reporting services by clinicians, who provide the principal care for a patient, with no planned endpoint of the relationship; services in this category represent comprehensive care, dealing with the entire scope of patient problems, either directly or in a care coordination role; reporting clinician service examples include, but are not limited to: primary care, and clinicians providing comprehensive care to patients in addition to specialty care
X2	Continuous/focused services: for reporting services by clinicians whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed with no planned endpoint to the relationship; reporting clinician service examples include but are not limited to: a rheumatologist taking care of the patient's rheumatoid arthritis longitudinally but not providing general primary care services
X3	Episodic/broad servies: for reporting services by clinicians who have broad responsibility for the comprehensive needs of the patient that is limited to a defined period and circumstance such as a hospitalization; reporting clinician service examples include but are not limited to the hospitalist's services rendered providing comprehensive and general care to a patient while admitted to the hospital
X4	Episodic/focused services: for reporting services by clinicians who provide focused care on particular types of treatment limited to a defined period and circumstance; the patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention; reporting clinician service examples include but are not limited to, the orthopedic surgeon performing a knee replacement and seeing the patient through the postoperative period
X5	Diagnostic services requested by another clinician: for reporting services by a clinician who furnishes care to the patient only as requested by another clinician or subsequent and related services requested by another clinician; this modifier is reported for patient relationships that may not be adequately captured by the above alternative categories; reporting clinician service examples include but are not limited to, the radiologist's interpretation of an imaging study requested by another clinician
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service
Z	
ZA	Novartis/sandoz (Terminated on 03/31/2018)
ZB	Pfizer/hospira (Terminated on 03/31/2018)
ZC	Merck/samsung bioepis (Terminated on 03/31/2018)

CPT Range and Accepted Modifiers List

Type Of Service	CPT Code Range	Accepted Modifiers
Anesthesia	00100 — 01999	AA
Surgery	10000 — 69999	22, 50, 51, 62, 80, 81, 59, 78, 79
Radiology	70010 — 79999	22, 52, 26, 76, 77
LAB Codes	80000 — 89999	QW
Medicine	90701 — 99199	26
E/M Codes	99201 — 99499	25

Modifier Range as per Medical Services

List of Modifiers for Medical Billing Used in Daily Claims:

CPT Modifiers are also playing an important role to reduce the denials also. Using the correct modifier is to reduce the claims defect and increase the clean claim rate also. The updated list of modifiers for medical billing is mention below

Modifier	Description
Modifier 22	Unusual procedure
Modifier 23	Unusual Anesthesia
Modifier 24	Unrelated E/M service
Modifier 25	Separate or distinct or Bundled E/M service
Modifier 26	Professional Component

Modifier 32	Mandatory Services
Modifier 33	Preventive Services
Modifier 50	Bilateral Services (Both Side)
Modifier 51	Multiple Procedure
Modifier 52	Reduced Services
Modifier 53	Discontinued Procedure
Modifier 54	Surgical care Only
Modifier 55	Postoperative Management
Modifier 56	Preoperative Management
Modifier 57	Decision of Surgery
Modifier 58	Staged or related Procedure
Modifier 59	Bundled Service
Modifier 76	Repeat procedure, same provider
Modifier 77	Repeat procedure, different provider
Modifier 78	Unplanned return to operating room during postoperative care, related procedure by the same provider.
Modifier 79	Unplanned return to the operating room during postoperative care, unrelated procedure by same provider.
Modifier 80	Assistant Surgeon
Modifier 81	Minimum Assistant Surgeon
Modifier 82	Assistant Surgeon when qualified surgeon not present.
Modifier 99	Multiple Modifiers
Modifier GW	Procedure not related to patients' Hospice condition.
Modifier QW	CLAIA Wave Test- Lab Test
Modifier TC	Technical Component

Most Used CPT Modifiers List- Common Modifiers List

List of CPT Modifiers 2023 Pdf

This sheet is latest updated on 05/22.

Modifiers List in Medical Billing Pdf Download

HealthPartners Standard Modifier Table Pdf

HealthPartners 2023 Modifier List for All Products below,

HealthPartners Standard Modifiers List with Allowed Percentage Download
Modifiers List in Medical Billing are mostly not updated every year but if we will get new updates on modifiers, update this list.

Related Articles:

CPT Codes in Medical Billing

Modifier 51 Code- The Secrets Revealed

Modifier TC Description

Modifier 76- A lot behind the Code

Modifier 79- The Facts to Know About

Modifier CS and Modifier 95 Definition

Modifiers List in Medical Billing 2023
Modifier CS and Modifier 95 Definition (2023)
Modifier 79- The Facts to Know About (2023)
Modifier 76- A lot behind the Code (2023)
Modifier 51 Code- The Secrets Revealed! (2023)

Author

NSingh (MBA, RCM Expert)

The author and contributor of this blog "NSingh" is working in Medical Billing and Coding since 2010. He is MBA in marketing and Having vaste experience in different scopes of Medical Billing and Coding as AR-Follow-up, Payment Posting, Charge posting, Coding, etc.

View all posts

List of Modifiers
HCPCS modifiers, list of modifiers in medical billing, medical billing modifiers list, modifier, modifiers, Modifiers list, Modifiers list in healthcare
‹ BCBS Prefix List 2023 | Alpha Lookup by State A-Z

Categories

BCBS Alpha Numeric Prefix List
Billing Codes
CPT Codes
Denial Codes
DRG Codes
Empire BCBS Prefix List

About Author

CPT is registered trademark of American Medical Association. The content shared in this website is for education and training purpose only.

Talcum Powder Lawsuit- Click to see if you qualify for a settlement !

Health Applications
Health Insurance
Healthcare Softwares
ICD Codes
Ins. Phone & Claim Add
List of Modifiers
Medical Billing & Coding
Medical Billing Codes
Medicare
Place Of Service
Product Reviews
Updates

The lead author and contributor of this blog NSingh is working in Medical Billing and Coding from 12+ years. Having vast experience in different scopes of Medical Billing and Coding as AR-Follow-up, Payment Posting, Charge posting, Coding, etc.

Free ICD10 Lookup Tool

Optimize Your Revenue Cycle with BellMedex Today