The information provided in this manual was current as of November 2010. Any changes or new information superseding the information in this manual, provided in newsletters/eBulletins, MLN articles, listserv notices, Local Coverage Determinations (LCDs) or CMS Internet-Only Manuals with publication dates after November 2010, are available at:

http://www.trailblazerhealth.com/Medicare.aspx

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Provider Outreach and Education
SH
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INTRODUCTION
Modifiers are used to modify payment of a procedure code, assist in determining appropriate coverage or otherwise identify the detail on the claim. The use of modifiers becomes more important every day when reporting services to ensure appropriate reimbursement from Medicare. These codes should be entered in Item 24d on the CMS-1500 claim form for paper billers. For electronic claims, use the following format.

<table>
<thead>
<tr>
<th>Loop 2400/SV101-1</th>
<th>Service ID Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loop 2400/SV101-2</td>
<td>Procedure Code</td>
</tr>
<tr>
<td>Loop 2400/SV101-3</td>
<td>Procedure Modifier 1</td>
</tr>
<tr>
<td>Loop 2400/SV101-4</td>
<td>Procedure Modifier 2</td>
</tr>
<tr>
<td>Loop 2400/SV101-5</td>
<td>Procedure Modifier 3</td>
</tr>
<tr>
<td>Loop 2400/SV101-6</td>
<td>Procedure Modifier 4</td>
</tr>
</tbody>
</table>

See “Part B Crosswalk to the CMS-1500 Claim Form” for electronic claims at:

http://www.trailblazerhealth.com/Publications/Job Aid/Crosswalkto1500ClaimForm.pdf
Modifiers

MODIFIERS

Ambulatory Surgical Center

SG  Ambulatory Surgical Center (ASC) Facility Service

(The SG modifier must accompany all codes billed by an ASC.) On or after January 1, 2008, the procedure code will not require the SG modifier.

73  Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to 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).

74  Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia: Due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc.).

FB  Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device

FC  Partial credit received for replaced device

For additional information regarding ASC billing, use the following link to the Ambulatory Surgery Center (ASC) training manual:


Anesthesia

Use the following modifiers with anesthesia procedure codes 00100–01999.

Anesthesia Services Billed by the Anesthesiologist

(Do not use the following modifiers if the provider of service is a Certified Registered Nurse Anesthetist (CRNA))

AA  Anesthesia services performed personally by anesthesiologist

QY  Medical direction of one CRNA by an anesthesiologist

QK  Medical direction of two, three or four concurrent anesthesia procedures
Modifiers

**AD**  Medical supervision by a physician, more than four concurrent anesthesia procedures

**Anesthesia Services Billed by the CRNA**
(Do not use the following modifiers if the provider of service is an anesthesiologist)

**QX**  CRNA service with medical direction by a physician

**QZ**  CRNA service without medical direction by a physician

**Monitored Anesthesia Care (MAC)**

**QS**  Monitored anesthesia care services

*Note:* Use the QS modifier in addition to the anesthesia modifiers.

**Anesthesia Physical Status Modifiers**
The following modifiers are informational only, no additional payment is allowed.

**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

**G8**  Monitored Anesthesia Care (MAC) for deep complex, complicated or markedly invasive surgical procedures

**G9**  Monitored anesthesia care for patient who has history of severe cardiopulmonary condition

For additional information regarding Anesthesia billing, use the following link to the *Anesthesia* training manual:

Modifiers

**Assistant Surgeon**
Medicare will make payment for an assistant-at-surgery when the procedure is covered for an assistant and one of the following situations exists:

- The person reporting the service is a physician.
- Or,
- The person bears the designation of a physician assistant, nurse practitioner, nurse midwife or clinical nurse specialist.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>Assistant surgeon</td>
</tr>
<tr>
<td>81</td>
<td>Minimum assistant surgeon</td>
</tr>
<tr>
<td>82</td>
<td>Assistant surgeon (when qualified resident surgeon not available)</td>
</tr>
<tr>
<td>AS</td>
<td>Physician Assistant (PA), Clinical Nurse Specialist (CNS) or Nurse Practitioner (NP) services for assistant-at-surgery</td>
</tr>
</tbody>
</table>

The allowed amount for assistant-at-surgery services is 16 percent of the physician fee schedule. The allowable for the assistant-at-surgery services performed by an NP, PA or a CNS is 85 percent of the 16 percent allowed based on the physician fee schedule.

**Bilateral**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>Bilateral procedure</td>
</tr>
</tbody>
</table>

Modifier 50 represents that the procedure was done bilaterally. To report bilateral services, report the procedure code with the 50 modifier and a unit of one in Item 24g of the CMS-1500 claim form or the electronic equivalent.

**Chiropractic Services**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT</td>
<td>Acute treatment</td>
</tr>
</tbody>
</table>

**Note:** Use this modifier with CPT codes 98940, 98941 and 98942 only.

For additional information regarding chiropractic billing, use the following link to the *Chiropractic Services* training manual:

Modifiers

**Competitive Acquisition Program (CAP)**

- J1 “No pay” modifier for drug line
- J2 Emergency re-supply
- J3 “Furnish as Written”
- M2 Medicare Secondary Payer

**Note:** The JW modifier is not used on claims for CAP drugs.

**Coronary Artery**

- LC Left circumflex coronary artery
- LD Left anterior descending coronary artery
- RC Right coronary artery

Use these modifiers to indicate the specific vessel involved in the procedure; they are only valid for CPT codes 92980, 92981, 92982, 92984, 92995 and 92996.

**Disaster-Related Claims**

- CR Disaster-related claims
- CS Gulf oil spill 2010 related

  For dates of service on or after April 20, 2010, use of the CS modifier is mandatory for applicable HCPCS codes on any claim for which the provider or supplier seeks Medicare Part B payment for treatment of illnesses, injuries or conditions arising from the Gulf oil spill or related circumstances.

**CR 7087:**  

**Drugs and Biologicals**

- JW Drug amount discarded/not administered to any patient

  Medicare will cover the amount of the drug that is reasonable and necessary for the patient’s condition. If a physician must discard the remainder of a vial after administering a portion to a Medicare patient, the Medicare program may cover a small, but reasonable amount of discarded drug, along with the amount administered. Medicare expects this wastage to be minimal. The provider should make an effort to schedule patients in such a way that they can minimize any waste and use the drug most efficiently.
Modifiers

The JW modifier, billed on a separate line, will provide payment for the amount of discarded drug or biological. For example, a single-use vial that is labeled to contain 100 units of a drug has 95 units administered to the patient and five units discarded. The 95-unit dose is billed on one line, while the discarded five units may be billed on another line by using the JW modifier. Both line items would be processed for payment. The JW modifier is only applied to the amount of drug or biological that is discarded. Any amount wasted must be clearly documented in the chart with the time, amount of medication wasted and the reason for the wastage.

The JW modifier is not used on claims for CAP drugs.

See Pub. 100-04, Medicare Claims Processing Manual, Chapter 17, Section 40, for additional information on discarded drugs and biologicals.

KD Drug or biological infused through DME

For information on billing Part B drugs used in an implantable infusion pump, use the following link:

http://www.trailblazerhealth.com/Publications/Job Aid/B Drugs Used Implantable Infusion Pump.pdf

End Stage Renal Disease (ESRD)

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

For additional information on ESRD and Medicare Secondary Payer (MSP), use the following link to the Medicare Secondary Payer and Patient Registration/Screening training manual:


Effective January 1, 2011

AY Item or service furnished to an ESRD patient that is not for the treatment of ESRD.

See the MNL Matters® article MM7064 for more information:
Modifiers

**Erythropoiesis-Stimulating Agents (ESAs) Administered to Non-ESRD Patients**

Effective January 1, 2008, all non-ESRD claims billing HCPCS J0881 and J0885 must report one of the following modifiers:

- **EA** ESA, anemia, chemo-induced
- **EB** ESA, anemia, radio-induced
- **EC** ESA, anemia, non-chemo/radio

**Evaluation and Management (E/M)**

**AI** Principal Physician of Record: Effective for dates of service on or after January 1, 2010, modifier AI should be used by the admitting or attending physician who oversees the patient’s care, as distinct from other physicians who may be furnishing specialty care. The principal physician of record shall append modifier AI in addition to the initial visit code. All other physicians who perform an initial evaluation on this patient shall bill only the E/M code for the complexity level performed.

**Note:** The primary purpose of this modifier is to identify the principal physician of record on the initial hospital and nursing home visit codes.


**Payment for E/M Services Provided During Global Period of Surgery**

24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period: The physician may need to indicate that an evaluation and management 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 Evaluation and Management 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 of the E/M services on the
Modifiers

same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Note: Do not use this modifier to report an E/M service that resulted in a decision to perform surgery; see modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

57 Decision for Surgery: An 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.

Documentation to support the above service(s) must be reflected in the patient’s medical records. Medicare does not request this documentation be sent at the time the claim is filed but it must be in the patient’s medical records and provided to Medicare upon request.

Note: Refer to the Medicare Physician Fee Schedule Database (MPFSDB) to determine the global period for surgical procedures.

Eye

E1 Upper left eyelid
E2 Lower left eyelid
E3 Upper right eyelid
E4 Lower right eyelid
LS FDA-monitored intraocular lens implant

Foot

Q7 One class A finding
Q8 Two class B findings
Q9 One class B and two class C findings
TA Left foot, great toe
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
Modifiers

T6 Right foot, second digit
T7 Right foot, third digit
T8 Right foot, fourth digit
T9 Right foot, fifth digit

For additional information on billing foot care, use the following link:

http://www.trailblazerhealth.com/Specialty_Services/Podiatry/default.aspx?DomainID=1

Hand

FA Left hand, thumb
F1 Left hand, second digit
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

Health Professional Shortage Area (HPSA)
The Health Professional Shortage Area (HPSA) incentive is a 10 percent bonus payment paid to physicians for the professional services provided in a qualified HPSA area.

AQ Physician providing a service in an HPSA

For more information on HPSA, use the following link:

http://www.trailblazerhealth.com/Publications/Job_Aid/HPSABonusPayments-PartB.pdf

AZ Physician providing a service in a dental health professional shortage area for the purpose of an Electronic Health Record (EHR) incentive payment
Modifiers

Effective for dates of service on or after January 1, 2010, CMS has developed modifier AZ for eligible professionals to report claims rendered in a dental HPSA when the ZIP code does not fully fall within the dental HPSA.

CR 7035:  

Hospice

GW  Service not related to the hospice patient’s terminal condition
GV  Attending physician not employed or paid under arrangement by the patient’s hospice provider

For billing instructions on hospice modifiers, the “Part B Hospice Modifiers GV and GW” job aid can be found on the TrailBlazer Web site at:

http://www.trailblazerhealth.com/Publications/Job Aid/HospiceModifiersGVGW.pdf

Kidney Donor

Q3  Live kidney donor surgery and related services

For additional information regarding a kidney donor, use the following link to the Nephrology and Dialysis training manual:


Laboratory

91  Repeat clinical diagnostic laboratory test
LR  Laboratory round trip
QW  CLIA waived test
90  Referenced (outside) laboratory

For additional information on billing laboratory services, use the following link:

http://www.trailblazerhealth.com/Publications/Training Manual/Lab-Path.pdf

Locum Tenens

Q6  Services furnished by a locum tenens physician
Modifiers

For additional information on Locum Tenens, use the following link to the Locum Tenens/Reciprocal Billing training manual:


**National Correct Coding Initiative (NCCI)**

59  Distinct procedural service

The physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day.

Use modifier 59 to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent:

- A different session or patient encounter.
- Different procedure or surgery.
- Different site or organ system.
- Separate incision/excision.
- Separate lesion.
  - Or,
- Separate injury (or area of injury in extensive injuries).

The medical record must reflect that the modifier is being used appropriately to describe separate services. The documentation should be maintained in the patient’s medical record and must be made available to Medicare upon request.

For additional information on NCCI, use the following link to the National Correct Coding Initiative and Medically Unlikely Edits training manual:


**Patient Care in Clinical Research Studies**

Effective for dates of service on and after January 1, 2008.

Q0  Investigational clinical service provided in a clinical research study that is in an approved clinical research study.

Investigational clinical services are defined as those items and services that are being investigated as an objective within the study. Investigational clinical services may include items or services that are approved, unapproved or otherwise covered (or not covered) under Medicare.
Modifiers

Q1 Routine clinical service provided in a clinical research study that is in an approved clinical research study.

Routine clinical services are defined as those items and services that are covered for Medicare beneficiaries outside of the clinical research study, are used for the direct patient management within the study, and do not meet the definition of investigational clinical services. Routine clinical services may include items or services required solely for the provision of the investigational clinical services (e.g., administration of a chemotherapeutic agent); clinically appropriate monitoring, whether or not required by the investigational clinical service (e.g., blood tests to measure tumor markers); and items or services required for the prevention, diagnosis or treatment of research-related adverse events (e.g., blood levels of various parameters to measure kidney function).

Physical/Occupational Therapy

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
KX Requirements specified in the medical policy have been met

Note: The KX modifier is to be used for therapy services that exceed the financial limitations and meet the automatic exceptions process for services rendered.

For additional information on physical/occupational therapy, use the following link to the Therapy Services training manual:


Physician Scarcity Area (PSA)
The PSA bonus is payable for dates of service January 1, 2005, through June 30, 2008.

AR Physician provided service in a PSA

Portable X-Ray

Only one of these five modifiers can be reported with R0075.

UN Two patients served
UP Three patients served
UQ Four patients served
UR Five patients served
**Modifiers**

US    Six patients or more served

*Physician Quality Reporting System (Physician Quality Reporting)*

The Physician Quality Reporting System (Physician Quality Reporting) establishes a financial incentive for eligible professionals to participate in a voluntary quality reporting program.

1P   Performance measure exclusion modifier due to medical reasons

2P   Performance measure exclusion modifier due to patient reasons

3P   Performance measure exclusion modifier due to system reasons

8P   Performance measure reporting modifier – action not performed, reason not otherwise specified

For more information about Physician Quality Reporting, use the following links:


**Psychiatry**

AH   Clinical psychologist

AJ   Clinical social worker

These modifiers are used when the provider is not practicing independently but is instead an employee of a physician or other entity who bills for them. The services are being reported as “incident to” the physician’s service.

**Radiology and Pathology**

TC   Technical component

26   Professional component

GG   Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day

Effective for claims with dates of service on or after April 6, 2009, the following new modifiers for PET scans have been created:

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.
Modifiers

PS  Positron Emission Tomography (PET) or PET/Computed Tomography (CT) to inform the subsequent treatment strategy of cancerous tumors when the beneficiary’s treatment physician determines that the PET study is needed to inform subsequent anti-tumor strategy.

For more information, refer to Change Request (CR) 6632.

**Reciprocal Billing**

Q5  Service furnished by a substitute physician under a reciprocal billing arrangement

For additional information on reciprocal billing, use the following link to the *Locum Tenens/Reciprocal Billing* training manual:


**Repeat Procedures**

76  Repeat Procedure or Service by the 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 or 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.

**Surgical Modifiers**

For additional information on surgery billing, use the following link to the *Surgery* training manual:


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 (i.e., increased intensity, time, technical difficulty of procedure, severity of patient’s condition, physical and mental effort required).

Medicare requires an operative report and a cover letter with this modifier. The 22 modifier should be used when a case is clearly out of the range of ordinary difficulty for that type of procedure.
Modifiers

Modifier 22 Example:

Using an example of a gallbladder surgery, if a patient weighed 300 pounds and had previous upper abdominal surgery such that adhesions in the upper abdomen were extremely dense, the gallbladder was densely adherent to the gallbladder bed on the liver and the surgery time was two and one-half hours, that would be a case where the surgeon is justified in using the 22 modifier and asking for extra reimbursement.

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 modifier 51 to the additional procedure or service code(s).

The standard Medicare system handles multiple surgery logic automatically without the presence of a 51 modifier. The use of the 51 modifier in an incorrect situation will cause the related claim line to either reject or deny. Please note the 51 modifier is not required to report multiple surgeries. The use of modifier 51 for billing purposes by providers is discouraged and can adversely affect payment if used incorrectly. However, the correct use of modifier 51 will not have an adverse affect on your claim.

52 Reduced Services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician’s discretion.

Medicare requires an operative report for surgical procedures and a concise statement as to how the reduced service is different from the standard procedure. Both of these documents are needed to determine the correct payment allowance based on the procedure performed.

Claims for non-surgical services reported with modifier 52 must contain a statement as to how the reduced service is different from the standard service. You may include other documentation (submitted with claim or faxed), but it is not necessary if the statement can convey the scope of the reduced service. If a statement explaining the reduction of the service or procedure is not submitted, the code billed with the 52 modifier will be denied.

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.

An operative report is required as well as a statement as to how much of the original procedure was accomplished.
## Modifiers

**Note:** Do not use this modifier to report the elective cancellation of a service prior to the patient’s anesthesia induction and/or surgical preparation in the operating suite.

### 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:

- Planned or anticipated (staged).
- More extensive than the original procedure.
  
  Or,

- For therapy following a surgical procedure.

This circumstance may be reported by adding modifier 58 to the staged or related procedure.

### 62 Two Surgeons:
When two surgeons work together as primary surgeons performing a distinct part(s) of a procedure, each surgeon should report the distinct operative work by adding the modifier 62 to the procedure code and any associated add-on code for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added.

Medicare requires an operative report.

### 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 modifier 66 to the basic procedure used for reporting services.

Medicare requires an operative report.

### 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 the operating or procedure room, it may be reported by adding modifier 78 to the related procedure.

### 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.

Wrong Surgical or Other Invasive Procedures Performed on a Patient (CR 6405)

Hospital outpatient departments, ASCs, practitioners and those submitting other appropriate types of bills are required to append one of the following National Coverage Determination (NCD) modifiers to all lines related to the erroneous surgery(ies) with dates of service on or after January 15, 2009.

- PA Surgery wrong body part
- PB Surgery wrong patient
- PC Wrong surgery on patient

Refer to the CMS MLN Matters® article at:

Split Care

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.

Example for Billing Split Care

Dr. Jones performed surgery March 2, 2009. Dr. Jones would bill the surgery with the 54 modifier. Dr. Smith assumed the postoperative care for the entire 90 days beginning March 3, 2009 (the day after surgery is when the 90-day postoperative period begins). Dr. Smith then relinquished care May 31, 2009.

Dr. Jones would bill as follows:

<table>
<thead>
<tr>
<th>CMS-1500 Claim Form or Electronic Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 24a</td>
</tr>
<tr>
<td>030209</td>
</tr>
</tbody>
</table>
Dr. Smith would bill as follows:

<table>
<thead>
<tr>
<th>CMS-1500 Claim Form or Electronic Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 19</td>
</tr>
<tr>
<td>Item 24a</td>
</tr>
<tr>
<td>Item 24d</td>
</tr>
<tr>
<td>Item 24f</td>
</tr>
<tr>
<td>Item 24g</td>
</tr>
</tbody>
</table>

See “Part B Crosswalk to the CMS-1500 Claim Form” for electronic claims at:

http://www.trailblazerhealth.com/Publications/Job_Aid/Crosswalkto1500ClaimForm.pdf

**Teaching Physician**

GC These services have been performed by a resident under the direction of a teaching physician

GE Service performed by a resident without the presence of a teaching physician under the primary care exception

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).

For additional information regarding teaching physicians, refer to the *Medicare Claims Processing Manual*, Chapter 12, Section 100:


**Miscellaneous**

GA Use to signify that the beneficiary has been given notice that certain Medicare services and supplies might not be considered medically reasonable and necessary. Waiver of liability statement issued, as required by payer policy.
## Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GZ</td>
<td>Use when an item or service is expected to be denied as not reasonable and necessary and an ABN has not been signed.</td>
</tr>
<tr>
<td>GJ</td>
<td>“Opt Out” physician or practitioner service provided in an emergency or urgent service</td>
</tr>
<tr>
<td>GT</td>
<td>Via interactive audio and video telecommunication systems</td>
</tr>
<tr>
<td>LT</td>
<td>Left side</td>
</tr>
<tr>
<td>RT</td>
<td>Right side</td>
</tr>
<tr>
<td>99</td>
<td>Multiple modifiers</td>
</tr>
<tr>
<td>CC</td>
<td>Procedure code change. (When the procedure code submitted was changed by Medicare either for administrative reasons or because an incorrect code was filed.)</td>
</tr>
<tr>
<td>QJ</td>
<td>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). For outpatient claims, providers should append modifier QJ on all lines with a line item date of service during the incarceration period. All associated charges should be billed as non-covered.</td>
</tr>
<tr>
<td>JW</td>
<td>Unused drugs. (The JW modifier is not used with CAP drugs.)</td>
</tr>
<tr>
<td>GY</td>
<td>Item or service statutorily excluded or does not meet the definition of any Medicare benefit.</td>
</tr>
<tr>
<td>KX</td>
<td>Requirements specified in the medical policy have been met</td>
</tr>
</tbody>
</table>

The KX modifier is a multipurpose informational modifier for Part B professional claims.

This modifier should also be used to identify services that are gender-specific (i.e., services that are considered female or male only) for affected beneficiaries on claims submitted by physicians and non-physician practitioners to Medicare carriers and Medicare Administrative Contractors (MACs). Use of the KX modifier will alert the carrier/MAC that the physician/practitioner is performing a service on a patient for whom gender-specific editing may apply, and that the service should be allowed to continue with normal processing. Payment will be made if the coverage and reporting criteria have been met for the service.


The KX modifier is also used for therapy services that exceed the financial limitations and meet the automatic exceptions process for services rendered on or after January 1, 2006, through December 31, 2009.
Modifers

For additional information on therapy services, use the following link to the Therapy Services training manual:


PT  Colorectal cancer screening test; converted to diagnostic test or other procedure

Effective January 1, 2011.

The deductible is waived for all surgical procedures (CPT code range of 10000 to 69999) furnished on the same date and in the same encounter as a colonoscopy, flexible sigmoidoscopy, or barium enema that were initiated as colorectal cancer screening services. Append modifier PT to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening sigmoidoscopy HCPCS code. The claims processing system will respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. Coinsurance will continue to apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as, the screening test.
# REVISION HISTORY

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2008</td>
<td>• Revised modifiers based on 2008 CPT description.</td>
</tr>
<tr>
<td></td>
<td>• Added modifiers FB and FC to Ambulatory Surgery Center (ASC) modifiers. Reference Change Request (CR) 5680.</td>
</tr>
<tr>
<td></td>
<td>• Removed invalid modifiers.</td>
</tr>
<tr>
<td>February 2008</td>
<td>• Added new modifiers Q0 and Q1. Reference CR 5805.</td>
</tr>
<tr>
<td></td>
<td>• Updated Web links.</td>
</tr>
<tr>
<td></td>
<td>• Extended dates for Physician Scarcity Area (PSA), reference CR 5937.</td>
</tr>
<tr>
<td></td>
<td>• Added instructions for using modifier 52.</td>
</tr>
<tr>
<td>March 2008</td>
<td>• Added new modifiers EA, EB and EC. Reference CR 5699.</td>
</tr>
<tr>
<td></td>
<td>• JW modifier not used on claims for Competitive Acquisition Program (CAP) drugs. Reference CR 5923.</td>
</tr>
<tr>
<td>November 2008</td>
<td>• Updated link to the 2008 Ambulatory Surgery Center training manual.</td>
</tr>
<tr>
<td></td>
<td>• Corrected modifier MS to be M2.</td>
</tr>
<tr>
<td>July 2009</td>
<td>• Added flow chart for hospice modifiers GV and GW.</td>
</tr>
<tr>
<td></td>
<td>• Updated electronic format for CMS-1500 claim form.</td>
</tr>
<tr>
<td></td>
<td>• Added Web link for job aid for Health Professional Shortage Area (HPSA).</td>
</tr>
<tr>
<td></td>
<td>• Added Web link for the Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing Initiative (E-Prescribing) manual.</td>
</tr>
<tr>
<td></td>
<td>• Added new modifiers PA, PB, PC. Reference CR 6405.</td>
</tr>
<tr>
<td></td>
<td>• Added new modifiers PI, PS, reference CR 6464.</td>
</tr>
<tr>
<td></td>
<td>• Added examples for billing split care.</td>
</tr>
<tr>
<td></td>
<td>• Added Web link to “Part B Crosswalk to the CMS-1500 Claim Form” for electronic claims.</td>
</tr>
<tr>
<td>September 2009</td>
<td>• Removed the KX modifier and note for PET scans. CR 6632 replaces CR 6464.</td>
</tr>
<tr>
<td>December 2009</td>
<td>• Extends KX modifier to multipurpose modifier per CR 6638.</td>
</tr>
<tr>
<td></td>
<td>• Revised description of the GC modifier per CR 6706.</td>
</tr>
<tr>
<td></td>
<td>• Revised chart for billing hospice modifiers GV and GW.</td>
</tr>
</tbody>
</table>
## Modifiers

<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>December 2009</td>
<td>Added the AI modifier per CR 6740 effective January 1, 2010.</td>
</tr>
<tr>
<td>March 2010</td>
<td>Removed dates from instructions on the KX modifier. Refer to the Physical Medicine and Rehabilitation training manual.</td>
</tr>
<tr>
<td>May 2010</td>
<td>• Changed definition of the GA modifier per CR 6563 effective April 1, 2010.</td>
</tr>
<tr>
<td></td>
<td>• Added additional information to the QJ modifier per CR 6880 effective July 9, 2010.</td>
</tr>
<tr>
<td></td>
<td>• Added additional information to the JW modifier per CR 6711 effective July 30, 2010.</td>
</tr>
<tr>
<td></td>
<td>• Added Web link for billing purposes regarding hospice modifiers GV and GW.</td>
</tr>
<tr>
<td>September 2010</td>
<td>• Added modifier AY. Effective January 1, 2011, per CR 7064.</td>
</tr>
<tr>
<td></td>
<td>• Changed references of <em>Physical Therapy</em> manual to <em>Therapy Services</em> manual.</td>
</tr>
<tr>
<td>December 2010</td>
<td>• <em>Added modifier CS. Effective April 20, 2010, CR 7087.</em></td>
</tr>
<tr>
<td></td>
<td>• <em>Added modifier AZ. Effective January 1, 2011, CR 7035.</em></td>
</tr>
<tr>
<td></td>
<td>• <em>Added modifier PT. Effective January 1, 2011, CR 7012.</em></td>
</tr>
</tbody>
</table>