Appendix B
HCPCS Level II Modifiers, Lay Descriptions, and Tips

Mod	Modifier Description, Definition, Explanation, and Tips
A1	**Dressing for one wound** **Definition:** Append modifier A1 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of a single wound. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A1 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of one wound. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with Healthcare Common Procedure Coding System, or HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the surgical dressing. Incorrect use may lead to denial or underpayment.
A2	**Dressing for two wounds** **Definition:** Append modifier A2 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of two wounds. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A2 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of two wounds. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the dressing. Incorrect use may lead to denial or underpayment.
A3	**Dressing for three wounds** **Definition:** Append modifier A3 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of three wounds. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A3 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of three wounds. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the dressing. Incorrect use may lead to denial or underpayment.
A4	**Dressing for four wounds** **Definition:** Append modifier A4 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of four wounds. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A4 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of four wounds. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the dressing. Incorrect use may lead to denial or underpayment.

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A5	**Dressing for five wounds** **Definition:** Append modifier A5 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of five wounds. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A5 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of five wounds. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the dressing. Incorrect use may lead to denial or underpayment.
A6	**Dressing for six wounds** **Definition:** Append modifier A6 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of six wounds. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A6 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of six wounds. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the dressing. Incorrect use may lead to denial or underpayment.
A7	**Dressing for seven wounds** **Definition:** Append modifier A7 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of seven wounds. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A7 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of seven wounds. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the dressing. Incorrect use may lead to denial or underpayment.
A8	**Dressing for eight wounds** **Definition:** Append modifier A8 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of eight wounds. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A8 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of eight wounds. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the dressing. Incorrect use may lead to denial or underpayment.

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A9	**Dressing for nine or more wounds** **Definition:** Append modifier A9 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of nine or more wounds. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A9 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of nine or more wounds. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the dressing. Incorrect use may lead to denial or underpayment.
AA	**Anesthesia services performed personally by anesthesiologist** **Definition:** Append this modifier to anesthesia service codes when the provider personally performs the entire anesthesia service. **Explanation:** This modifier documents the service of the provider who personally provides the anesthesia during the entire surgical procedure. This modifier is also applicable when the provider is continuously supervising a student anesthetist during the procedure or when the procedure involves the provider with one resident. To report modifier AA, the provider continuously monitors a single case. The provider must remain physically present in the operating room during the entire procedure when billing the personally performed modifier AA. **Tips:** If the provider does not continuously monitor the single case, use another appropriate modifier such as AD, Medical supervision by a physician: more than four concurrent anesthesia procedures.
AB	**Audiology service furnished personally by an audiologist without a physician/npp order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids; service may be performed once every 12 months, per beneficiary** **Definition:** Append modifier AB to the code for a nonacute hearing assessment furnished by an audiologist without an order. **Explanation:** Append this modifier to the code for an audiology service that the audiologist provides personally without an order from a treating physician or nonphysician practitioner (NPP). The service should be a nonacute hearing assessment not related to disequilibrium (imbalance) or hearing aid services. The patient may have the service with this modifier appended once per 12 months.
AD	**Medical supervision by a physician: more than four concurrent anesthesia procedures** **Definition:** An anesthesiologist provides medical supervision for more than four procedures that overlap each other. **Explanation:** When a physician performs medical supervision of more than four concurrent procedures with anesthesia services by others, such as CRNAs, the physician appends modifier AD. Concurrent means that there is some degree of overlap in the procedures. Depending on payer rules, one minute of overlap may be enough for procedures to be considered concurrent. **Tips:** Check payer rules regarding use of modifier AD. The payer may recognize an additional time unit if the physician can document she was present at induction for general anesthesia.
AE	**Registered dietician** **Definition:** Append this modifier to indicate the services of a nutrition professional. **Explanation:** This modifier indicates the services of a nutrition professional or a registered dietician on claims with medical nutrition therapy codes such as 97802 to 97804, and G0270 to G0271. This code may also be applicable to Diabetes outpatient self management training services, or DSMT, reportable under G0108 individual, per 30 minutes and G0109, group session, 2 or more, per 30 minutes. **Tips:** Use this modifier to represent the professional services of a nutrition professional or a registered dietician in a critical access hospital, or CAH. An all inclusive rate payment methodology applies in the case of a CAH.
AF	**Specialty physician** **Definition:** Append this modifier to indicate the services of a specialty physician in a physician scarcity area. **Explanation:** Modifier AF is a Medicare use only modifier that represents the services of a specialty physician in a physician scarcity area, or a geographic area with a shortage of primary care doctors or specialists available to the Medicare population in that area. Use of this modifier provides for a quarterly bonus payment along with claim payment. Behavioral Medicine, Oncology, Endocrinology, Neurology, Neurosurgery, and Orthopedics, are some examples of specialty physicians. **Tips:** Use this modifier to represent professional services of a specialty physician in a physician scarcity area in a critical access hospital.

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AG	**Primary physician** **Definition:** Append this modifier to indicate the services of a primary care physician in a physician scarcity area. **Explanation:** Modifier AG is a Medicare use only modifier that represents the services of a primary care physician in a physician scarcity area, or a geographic area with a shortage of primary care doctors or specialists available to the Medicare population in that area. Use of this modifier provides for a quarterly bonus payment along with claim payment. A primary care physician is typically defined as a general practitioner, family practice practitioner, general internist, pediatrician, obstetrician, or gynecologist. **Tips:** Use this modifier to represent professional services of a primary physician in a physician scarcity area in a critical access hospital.
AH	**Clinical psychologist** **Definition:** Append this modifier to indicate the services of a clinical psychologist. **Explanation:** This modifier indicates the services the provider is reporting are for a qualified clinical psychologist for the psychiatric therapeutic procedures that he performs for a patient in a facility. The modifier indicates that a clinical psychologist, who qualifies as per Medicare guidelines to provide these services, is performing the service the facility is reporting under the CPT® code for the procedure. **Tips:** When the facility uses this modifier with any CPT® code, it lets the payer know that a qualified clinical psychologist handled the services and reimbursement can be made as per Medicare payment guidelines. If you fail to append the right modifier to the CPT® code, it may lead to incorrect payments and fraudulent claims.
AI	**Principal physician of record** **Definition:** Append this modifier to the initial hospital and nursing home visit codes to show that the provider is responsible for the overall care of the patient. **Explanation:** This modifier indicates the service by the admitting or attending provider who oversees the patient's care, as distinct from other providers who may furnish specialty care. The principal provider of record shall append modifier AI to the initial visit code. The primary purpose of this modifier is to identify the principal provider of record on the initial hospital and nursing home visit codes. **Tips:** Remember that modifier AI is for inpatient use only, not for outpatient evaluation and management, or E/M, codes. Modifier AI is informational only and does not impact the payment.
AJ	**Clinical social worker** **Definition:** Append this modifier to indicate the services of a clinical social worker. **Explanation:** This modifier indicates the services of a qualified clinical social worker for therapeutic procedures that he performs in the facility. The modifier indicates that a clinical social worker, who qualifies as per Medicare guidelines to provide these services, is performing the service the facility is reporting under the CPT® code for the procedure. **Tips:** When the facility uses this modifier with any CPT® code, it lets the payer know that a qualified clinical social worker handled the services and reimbursement can be made as per CMS payment guidelines. If you fail to append the right modifier to the CPT® code, it may lead to incorrect payments and fraudulent claims.
AK	**Non participating physician** **Definition:** Append this modifier to indicate the services of a non participating physician. **Explanation:** This modifier indicates the services of a non participating provider who chooses not to participate in the Medicare fee schedule reimbursement, meaning he does not accept the Medicare approved amount as full payment for covered service. Medicare does not reimburse non participating physicians directly. Instead Medicare reimburses the patient for the allowable costs. The provider has to arrange for payment directly from the patient. **Tips:** Use this modifier to represent the services of a non participating physician in a critical access hospital.
AM	**Physician, team member service** **Definition:** Append this modifier to indicate the services of a member of a provider's team, usually a physician assistant who is part of the provider's team. **Explanation:** Append modifier AM if a physician assistant or other team member of the provider's team renders service. Usually, the supervising provider bills these services and the provider uses this modifier to indicate that his team member performs the service. **Tips:** This modifier is informational only and should not impact reimbursement. It just identifies that during the procedure the provider is not rendering the actual service but he is supervising the service.

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AO	**Alternate payment method declined by provider of service** **Definition:** Append this modifier to each line of service on a claim if the provider prefers to decline participation in an alternate payment method by the payer. **Explanation:** Modifier AO indicates that the provider declines an alternate payment methodology and wants to continue with the original method of reimbursement. Use this modifier if you do not prefer to participate in bundled payment program for example for a care improvement initiative under the Affordable care act and you would continue to receive the reimbursement according to regular fee for service payment rules. **Tips:** If the provider does not report the AO modifier on each line of service on the claim then the provider receives the claim back as unprocessable with instruction to rebill the services on separate claims.
AP	**Determination of refractive state was not performed in the course of diagnostic ophthalmological examination** **Definition:** Append this modifier to eye examination codes to indicate that reimbursement of the code does not include a fee for determination of a refractive state, or the process that the provider performs to determine the patient's refractive error and need for glasses or contact lenses. **Explanation:** This is an informational modifier that indicates that determination of a refractive state was not part of the work effort that the provider puts in diagnostic ophthalmological examination and the overall value of the eye examination codes such as 92004, 92014, 92002, 92012, do not include the value of refraction. **Tips:** Modifier AP became unnecessary when the values for the eye exam codes no longer included payment for refraction. If an ophthalmologist performed an eye exam without refraction, he would append modifier AP to show that the fee did not include refraction. CPT® gave refraction its own code, 92015, Determination of refractive state, which Medicare will not reimburse for, and excluded that work from the value of the eye exam codes. Since Medicare does not consider refraction an intrinsic part of any code, modifier AP is no longer necessary.
AQ	**Physician providing a service in an unlisted health professional shortage area (HPSA)** **Definition:** Append this modifier to represent the services that the provider renders in zip code areas that do not fall within a listed health professional shortage area, or HPSA. **Explanation:** Modifier AQ represents the provider's service in a health professional shortage area that is not listed in Medicare's annual file for automated HPSA bonus payment. CMS posts a file annually of ZIP codes, within which the HPSA bonus payment is made automatically. An unlisted health professional shortage area includes zip code areas that fall partially within a full county HPSA but is not considered to be in that county based on the United States Postal Service dominance decision; is a zip code area that falls partially within a non full county HPSA; is a zip code area that was not included in the automated file of HPSA areas based on the date the file was run, and zip code areas that do not fall entirely in a designated full county HPSA. **Tips:** Do not use this modifier if the provider does not render the service in the health professional shortage area. Do not use this modifier with codes that represent only a technical component.
AR	**Physician provider services in a physician scarcity area** **Definition:** Append this modifier to represent the services of a physician provider in a physician scarcity area. **Explanation:** Modifier AR represents the services that a provider performs in a physician scarcity area, or an area which has a shortage of health professionals. It was a previously effective code until June of 2008 and was used by the provider to obtain a physician scarcity area bonus payment. **Tips:** Use this modifier only for dates of service January 1, 2005, through June 30, 2008.
AS	**Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery** **Definition:** Append this modifier to represent the services of a healthcare professional acting as an assistant during a surgery. **Explanation:** Healthcare professionals like a physician assistant, nurse practitioner, or clinical nurse specialist who acts as an assistant during a surgery reports the identical procedure as the primary surgeon with a modifier AS. These professionals report these services under a surgeons' provider number. The main surgeon should clearly specify in the medical record the medical necessity for utilizing the service of an assistant.
AT	**Acute treatment (this modifier should be used when reporting service 98940, 98941, 98942)** **Definition:** Append this modifier with specific chiropractic manipulative treatment, or CMT, spinal codes when the provider performs treatment of the acute or chronic spinal subluxation. **Explanation:** The provider uses modifier AT with chiropractic manipulative treatment codes such as 98940 to 98942 to indicate the acute or active nature of treatment. The patient's medical record should also support the active nature of chiropractic treatment in that the record should reflect the anticipated result of the chiropractic manipulation is either an improvement in, or a complete arrest of the progression, of the patient's condition. **Tips:** This modifier is not applicable when the medical records suggest that the provider is performing a maintenance chiropractic service to maintain or further prevent deterioration of a chronic condition.

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AU	**Item furnished in conjunction with a urological, ostomy, or tracheostomy supply** **Definition:** Append this modifier with Healthcare Common Procedure Coding System, or HCPCS codes that identify the supply associated with urological, ostomy, or tracheostomy procedures. **Explanation:** Use this modifier with Healthcare Common Procedure Coding System, or HCPCS codes that a provider reports for supplies associated with a urological procedure, or those for the male and female urinary tract system and the male reproductive organs; an ostomy, or a surgically created opening in a patient's body for the discharge of body wastes; or for a tracheostomy, an opening made in the patient's neck into the trachea, or windpipe to create an airway or to remove secretions from the patient's lungs. **Tips:** Use modifier AU with HCPCS codes such as A4217; Sterile water or saline, 500 ml, A4450; Surgical trays, A4452; Tape, waterproof, per 18 square inches, and A5120; Skin barrier, wipes or swabs, each.
AV	**Item furnished in conjunction with a prosthetic device, prosthetic or orthotic** **Definition:** Append this modifier with Healthcare Common Procedure Coding System, or HCPCS codes that identify the supply associated with a prosthetic device, prosthetic, or orthotic. **Explanation:** Use this modifier with Healthcare Common Procedure Coding System, or HCPCS codes that a provider reports for supplies associated with a prosthetic device, prosthetic or orthotic, meaning an artificial or manmade replacement for a body part or a supportive device. **Tips:** Use modifier AV with HCPCS codes such as: A4450; Tape, non-waterproof, per 18 square inches, A4452; Tape, waterproof, per 18 square inches and A5120; Skin barrier, wipes or swabs, each. Providers can refer to the Medicare Durable Medical Equipment, Prosthetics or Orthotics and Supplies Fee Schedule on the Centers for Medicare and Medicaid Services, or CMS, website to determine which procedures are reportable with modifier AV. Allowable procedure codes for modifier AV appear on the file with modifier AV such as A4450 AV.
AW	**Item furnished in conjunction with a surgical dressing** **Definition:** Append this modifier with Healthcare Common Procedure Coding System, or HCPCS codes that identify the supply associated with a surgical dressing. **Explanation:** Use this modifier with Healthcare Common Procedure Coding System, or HCPCS codes that a provider reports for supplies associated with a surgical dressing, meaning a sterile bandage or compress applied to a wound to encourage healing and to prevent infection.
AX	**Item furnished in conjunction with dialysis services** **Definition:** Append this modifier to Healthcare Common Procedure Coding System, or HCPCS codes that identify a supply associated with a dialysis services. **Explanation:** Use this modifier for Healthcare Common Procedure Coding System, or HCPCS codes that a provider reports for items he furnishes that are dialysis supplies or equipment, but are not specifically identified as dialysis supplies or equipment in the code descriptor. Use modifier AX with dialysis supplies such as those codes in the ranges A4215 to A4217, A4244 to A4248, A4450, A4452, A4651 to A4670, A4927, A4928, A4930, A4931, A6216, A6250, A6260, and A6402. Use modifier AX also with dialysis equipment codes such as E0210, E1632, E1637, and E1639. **Tips:** A provider can report this code for items furnished in conjunction with home dialysis services too.
AY	**Item or service furnished to an ESRD patient that is not for the treatment of ESRD** **Definition:** Append this modifier to Healthcare Common Procedure Coding System, or HCPCS codes that represent an item or service she furnishes to an End Stage Renal Disease, or ESRD, patient that is not for the treatment of the ESRD. **Explanation:** This modifier was developed for only Medicare purposes. Under the bundled payment system, a single payment is made for renal dialysis services and other items and services for example, supplies and equipment the provider uses to administer dialysis, and the drugs, biologicals, laboratory tests, and support services related to home dialysis. However, if any End Stage Renal Disease, or ESRD facility provides any items or services to a beneficiary, which do not relate to the treatment of the patient's ESRD condition, then the ESRD facility submits those services using the AY modifier to allow for separate payment outside of ESRD bundled payment system. **Tips:** Use this modifier only when the documents clearly support that the service the provider performs for a reason unrelated to ESRD treatment.

Mod	Modifier Description, Definition, Explanation, and Tips
AZ	**Physician providing a service in a dental health professional shortage area for the purpose of an electronic health record incentive payment** **Definition:** Append this modifier to represent the services that a provider renders in zip codes areas that fall within a designated dental health professional shortage area, or HPSA to obtain the electronic health record, or EHR, incentive payment. **Explanation:** Modifier AZ represents the services that a provider performs in a dental physician scarcity area, or a geographic area with a shortage of dental health professionals available to the Medicare population in that area. Append this modifier to report services the provider renders in a dental HPSA when the Zip code does not fully fall within that dental HPSA. Use of this modifier provides for an electronic health record incentive payment, made to eligible providers that adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. **Tips:** This modifier does not impact the payment or calculation of the fee for service geographic quarterly HPSA, or health professional shortage area bonus.
BA	**Item furnished in conjunction with parenteral enteral nutrition (PEN) services** **Definition:** Append modifier BA to represent an item or service a provider furnishes in conjunction with parenteral enteral nutrition, or PEN, services. **Explanation:** A provider reports the BA modifier for items that a provider furnishes for use with parenteral enteral nutrition services. For example, when the provider uses an intravenous, or IV pole in conjunction with parenteral nutrition, and reports E0776, IV pole, the provider appends the BA modifier. **Tips:** Use the BA modifier with E0776 exclusively.
BL	**Special acquisition of blood and blood products** **Definition:** Append this modifier to Healthcare Common Procedure Code System, or HCPCS codes that the provider reports for the actual blood or blood product. **Explanation:** Use this modifier with appropriate blood product Healthcare Common Procedure Code System, or HCPCS codes that a provider uses in an outpatient hospital setting for example when he purchases the products from a community blood bank or when he assess a charge for the blood or blood product that the provider collects in his own blood bank. **Tips:** The provider reports charges for the blood or blood product itself with the date of service, the number of units, and the appropriate blood product HCPCS code and modifier BL. He also reports the processing and storage services on a separate line the same line item date of service, the same number of units, and the same appropriate blood product HCPCS code and modifier BL. This modifier is applicable for blood products payment under the hospital outpatient prospective payment system. There is no requirement for use of this modifier by critical access hospitals, or CAHs.
BO	**Orally administered nutrition, not by feeding tube** **Definition:** Append this modifier to enteral nutrition Healthcare Common Procedure Code System, or HCPCS codes when the provider administers enteral nutrition products by mouth. **Explanation:** A provider appends this modifier with Healthcare Common Procedure Code System, or HCPCS codes that he reports for enteral nutrition therapy. He administers the enteral nutrition products to the patient orally, or by mouth, and not through a feeding tube. This modifier is applicable for enteral nutrients, reportable using HCPCS codes B4149 to B4162. **Tips:** This modifier is applicable for certain Home Health and Hospice services as well.
BP	**The beneficiary has been informed of the purchase and rental options and has elected to purchase the item** **Definition:** Append modifier BP to a code for durable medical equipment where the provider informs the beneficiary of the purchase and rental options and the beneficiary elects to purchase the item. **Explanation:** Modifier BP indicates that the patient chooses to purchase a durable medical equipment, or DME, item after the provider fully informs the recipient at the time the patient receives the item of the purchase and rental options for the item. A provider appends this modifier for durable medical equipment, or DME, items such as parenteral and enteral, or PEN pumps and electric wheelchairs, reportable with HCPCS K0835 thru K0891. **Tips:** Medicare discontinued the use of the following modifiers on claims for most capped rental items outside of those identified above: BP, The beneficiary has been informed of the purchase and rental options and has elected to purchase the item, modifier BR, and modifier 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. This change was due to the implementation of Section 5101 of the Deficit Reduction Act of 2005.

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BR	**The beneficiary has been informed of the purchase and rental options and has elected to rent the item** **Definition:** Append modifier BR to a code for durable medical equipment, or DME, items where the provider informs the beneficiary of the differences between purchasing and renting of the DME item and the beneficiary chooses to rent the item. **Explanation:** Modifier BR identifies a code as an item where the beneficiary chooses to rent the item after the provider fully informs the recipient at the time the patient receives the item of the purchase and rental options available. A provider appends this modifier for durable medical equipment, or DME, items such as parenteral and enteral, or PEN pumps and electric wheelchairs, reportable with HCPCS K0835 through K0891. **Tips:** Medicare discontinued the use of the following modifiers on claims for most capped rental items outside of those identified above: BP, The beneficiary has been informed of the purchase and rental options and has elected to purchase the item, modifier BR, and modifier 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. This change was due to the implementation of Section 5101 of the Deficit Reduction Act of 2005.
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** **Definition:** Append modifier BU to a code for durable medical equipment, or DME, items where the provider informs the beneficiary of the differences between purchasing and renting the item and after 30 days the beneficiary has not informed the supplier of his decision. **Explanation:** Modifier BU identifies a code for a durable medical equipment, or DME, item that a provider fully informs the recipient at the time the patient receives the item of the purchase and rental options available but the beneficiary does not inform the supplier of his decision to rent or purchase the item for 30 days or more. A provider appends this modifier for certain durable medical equipment, or DME, items such as parenteral and enteral, or PEN, pumps and electric wheelchairs regardless of the date of the first rental period, reportable with HCPCS K0835 thru K0891, and on all capped rental items where the first rental period began prior to January 1, 2006. **Tips:** Medicare discontinued the use of the following modifiers on claims for most capped rental items outside of those identified above: BP, The beneficiary has been informed of the purchase and rental options and has elected to purchase the item, modifier BR, and modifier 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. This change was due to the implementation of Section 5101 of the Deficit Reduction Act of 2005.
CA	**Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission** **Definition:** Append modifier CA when the patient is an outpatient, in an inpatient setting, and the patient passes away without being admitted as an inpatient. **Explanation:** In order to receive payment for the CA modifier with a Healthcare Common Procedure Coding System, or HCPCS code, the patient should be an emergency patient and must be an outpatient, the setting should be an inpatient setting only, and the patient passes away without being admitted as an inpatient. For outpatients who receive inpatient only procedures on an emergency basis and who expire before inpatient admittance to the hospital, the provider receives a specific outpatient Ambulatory Payment Classification, or APC payment as reimbursement for all the services on that day. The assignment of a modifier CA on an inpatient only procedure line identifies the service as such and assigns the specific payment, and turns on a packaging flag for all other line items on that claim with that date of service. Payment is only permissible for one procedure with a modifier of CA. **Tips:** Do not use modifier CA on more than one procedure on a claim. If a provider submits multiple inpatient only procedures with the modifier CA, the payer returns the claim back to the provider. If a provider applies a modifier CA on an inpatient only procedure code for a patient who did not expire, and the patient discharge status code is not 20, Expired, then the provider will also get the claim back.
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** **Definition:** A provider appends modifier CB to identify services ordered by a renal dialysis facility, or RDF, provider as part of the dialysis benefit of an end stage renal disease, or ESRD patient. This is not a part of the composite rate payment, and is separately reimbursable. **Explanation:** A provider appends modifier CB to services related to an ESRD patient's dialysis treatment and ordered by the dialysis facility physician. The test is not a part of the dialysis facility's composite rate payment, and is separately reimbursable. These services may include chest X-rays and other X-rays presumptively considered to be dialysis related and, therefore, appropriate for submission with the CB modifier; along with lab tests such as certain panel tests, urinalysis, and specific electrocardiogram, or ECG, tests and some vascular studies. **Tips:** Modifier CB affects consolidated billing rules for skilled nursing facilities for inpatients. Append modifier CB, only after determining that the patient has ESRD entitlement, he is undergoing the test for dialysis treatment for ESRD, the test is an order of the dialysis facility, the test is not a part of the composite rate, and is separately reimbursable. The patient should be in a Medicare Part A stay, Bill 21X or 22X.

Mod	Modifier Description, Definition, Explanation, and Tips
CC	**Procedure code change (use 'CC' when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed)** **Definition:** A provider appends modifier CC to report a procedure code change, when the procedure code submitted changes either for administrative reasons, or due to filing of an incorrect code. **Explanation:** A provider appends modifier CC to a service when the procedure code submitted changes either for administrative reasons or due to incorrect code usage. Commonly, a contractor uses this modifier to identify when the procedure code submitted was changed by them. **Tips:** Providers should not use modifier CC. It is an internal modifier that identifies when the Medicare contractor changes the procedure code that the provider submitted.
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** **Definition:** Append modifier CD when the End Stage Renal Disease, or ESRD provider or any provider performs an automated multi channel laboratory test, or AMCC test on an ESRD patient who is undergoing maintenance dialysis. **Explanation:** Use this modifier when an End Stage Renal Disease, or ESRD provider or any provider performs an automated multi channel laboratory test, or AMCC, test on an ESRD patient who is undergoing maintenance dialysis. This modifier indicates that the test is a part of the composite rate and is not separately reimbursable. When a provider reports an individual laboratory code such as 82330, Calcium; ionized, as Monthly Capitation Payment, or MCP requires, rather than reporting the disease panel code, such as 82310, Calcium; total, he appends modifier CD, when the test is part of the composite rate or he appends CE, AMCC test has been ordered by an ESRD facility or MCP provider that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity. **Tips:** Providers billing AMCC ESRD related tests to Medicare must report CD, CE, or CF modifiers for each test. Beginning with dates of service on or after April 1, 2015, ESRD claims will no longer require ESRD facilities to submit theses three modifiers: CD, 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; or modifier 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.
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** **Definition:** Append modifier CE when the End Stage Renal Disease, ESRD facility or another facility performs an automated multi channel laboratory, or AMCC test on an ESRD patient who is undergoing maintenance dialysis. This modifier indicates that the test is beyond the normal frequency limit the composite reimbursement covers so it is separately payable. **Explanation:** Use this modifier when either the ESRD facility or another facility performs an automated multi channel laboratory, or AMCC test on an ESRD patient who is undergoing maintenance dialysis. This modifier indicates that the test is reasonable and medically necessary, a part of the composite rate, but is beyond the frequency limits and is separately reimbursable. When a provider reports an individual laboratory code such as 82330. Calcium; ionized, as the Monthly Capitation Payment, or MCP requires, rather than reporting the disease panel code, such as 82310, Calcium; total, he appends modifier 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, or he appends modifier CE when the code is separately reimbursable. **Tips:** Providers billing AMCC ESRD related tests to Medicare must report CD, CE, or CF modifiers for each test. Beginning with dates of service on or after April 1, 2015, ESRD claims will no longer require ESRD facilities to submit theses three modifiers: 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; or modifier CE; or 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.

Mod	Modifier Description, Definition, Explanation, and Tips
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** **Definition:** Append modifier CF when the End Stage Renal Disease, ESRD facility or an outside facility performs an automated multi channel laboratory, or AMCC, test on an ESRD patient undergoing maintenance dialysis. This modifier indicates that the test is not included in the composite rate and is separately reimbursable. **Explanation:** When submitting claims to Medicare for ESRD related automated multi channel chemistry tests, or AMCC tests, use modifier CF to identify which tests are not inclusive within the ESRD facility composite rate payment. Append modifier CF to identify tests that the provider orders that are not a part of the composite rate. These tests are separately reimbursable. Use modifier CF if the provider orders tests for chronic dialysis for ESRD such as an AMCC test that is not part of the composite rate and is separately billable and has been ordered by an ESRD facility or Monthly Capitation Payment, or MCP physician. You may submit this modifier with any of the AMCC codes. **Tips:** Providers billing AMCC ESRD related tests to Medicare must report CD, CE, or CF modifiers for each test. Beginning with dates of service on or after April 1, 2015, ESRD claims will no longer require ESRD facilities to submit these three modifiers: 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; or 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; or modifier CF.
CG	**Policy criteria applied** **Definition:** Append modifier CG to a code to identify a policy criteria applied. **Explanation:** For services reportable as an L3923 orthosis that has a rigid plastic or metal component, you must add the CG modifier. If you bill a claim for L3923 without a CG modifier, it will be denied. Similarly, if a spinal garment for example L0450, L0454, L0621, L0625, or L0628 is made primarily of a nonelastic material, such as canvas, cotton, or nylon, or has a rigid posterior panel, you must add the CG modifier or the service will be rejected or denied for incorrect coding. **Tips:** This modifier is informational only and you may submit it with all procedure codes.
CH	**0 percent impaired, limited or restricted** **Definition:** Append modifier CH to a code for a patient with a zero percent impairment, with limited or restricted movement. **Explanation:** Modifier CH identifies the extent of a patient's impairment. The severity of impairment to assign this modifier is zero percent impaired, with limited or restricted movement. CH is a severity modifier that a provider uses on specific therapy claims. Report only one functional limitation for each related therapy plan of care, or POC. In situations where a provider completes reporting on the first reportable functional limitation and the need for treatment continues, he reports a second functional limitation using another set of G codes. Functional reporting is necessary, at the beginning of a therapy episode of care, or on the date of service, or DOS, for the initial therapy service; at least once every ten treatment days; on the same DOS that a provider reports an evaluative or re evaluative on a claim; at the time of patient discharge from a therapy episode of care; and on the same DOS the reporting of a particular functional limitation ends, when further therapy is necessary. **Tips:** Use this modifier to report the severity or complexity for the functional measure for each non payable therapy G code. The severity modifiers reflect the patient's percentage of functional impairment as determined by the therapist, physician, or nonphysician practitioner who provides the therapy services. The appropriate severity modifiers report a patient's current status, the anticipated goal status, and the discharge status.

Mod	Modifier Description, Definition, Explanation, and Tips
CI	**At least 1 percent but less than 20 percent impaired, limited or restricted** **Definition:** Append modifier CI to a code for a patient with an impairment of one to 20 percent, with limited or restricted movement. **Explanation:** Modifier CI identifies the extent of impairment in a patient. The severity of impairment may range from one percent to 20 percent, with limited or restricted movement. CI is a severity modifier that a provider uses on specific therapy claims. Report only one functional limitation for each related therapy plan of care, or POC. In situations where a provider completes reporting on the first reportable functional limitation and the need for treatment continues, he reports a second functional limitation using another set of G codes. Functional reporting is necessary, at the beginning of a therapy episode of care, or on the DOS for the initial therapy service; at least once every ten treatment days; on the same DOS that a provider reports an evaluative or re evaluative on a claim; at the time of patient discharge from a therapy episode of care; and on the same DOS the reporting of a particular functional limitation ends, when further therapy is necessary. **Tips:** Use this modifier to report the severity or complexity for the functional measure for each non payable therapy G code. The severity modifiers reflect the patient's percentage of functional impairment as determined by the therapist, physician, or nonphysician practitioner who provides the therapy services. The appropriate severity modifiers report a patient's current status, the anticipated goal status, and the discharge status.
CJ	**At least 20 percent but less than 40 percent impaired, limited or restricted** **Definition:** Append modifier CJ to a code for a patient with an impairment of 20 to 40 percent, with limited or restricted movement. **Explanation:** Modifier CJ identifies the extent of impairment in a patient. The severity of impairment may range from 20 percent to 40 percent, with limited or restricted movement. CJ is a severity modifier that a provider uses on specific therapy claims. Report only one functional limitation for each related therapy plan of care, or POC. In situations where a provider completes reporting on the first reportable functional limitation and the need for treatment continues, he reports a second functional limitation using another set of G codes. Functional reporting is necessary, at the beginning of a therapy episode of care, or on the date of service, or DOS, for the initial therapy service; at least once every ten treatment days; on the same DOS that a provider reports an evaluative or re evaluative on a claim; at the time of patient discharge from a therapy episode of care; and on the same DOS the reporting of a particular functional limitation ends, when further therapy is necessary. **Tips:** Use this modifier to report the severity or complexity for the functional measure for each non payable therapy G code. The severity modifiers reflect the patient's percentage of functional impairment as determined by the therapist, physician, or nonphysician practitioner who provides the therapy services. The appropriate severity modifiers report a patient's current status, the anticipated goal status, and the discharge status.
CK	**At least 40 percent but less than 60 percent impaired, limited or restricted** **Definition:** Append modifier CK to a code for a patient with an impairment of 40 to 60 percent, with limited or restricted movement. **Explanation:** Modifier CK identifies the extent of impairment in a patient. The severity of impairment may range from 40 percent to 60 percent, with limited or restricted movement. CK is a severity modifier that a provider uses on specific therapy claims. Report only one functional limitation for each related therapy plan of care, or POC. In situations where a provider completes reporting on the first reportable functional limitation and the need for treatment continues, he reports a second functional limitation using another set of G codes. Functional reporting is necessary, at the beginning of a therapy episode of care, or on the date of service, or DOS, for the initial therapy service; at least once every ten treatment days; on the same DOS that a provider reports an evaluative or re evaluative on a claim; at the time of patient discharge from a therapy episode of care; and on the same DOS the reporting of a particular functional limitation ends, when further therapy is necessary. **Tips:** Use this modifier to report the severity or complexity for the functional measure for each non payable therapy G code. The severity modifiers reflect the patient's percentage of functional impairment as determined by the therapist, physician, or nonphysician practitioner who provides the therapy services. The appropriate severity modifiers report a patient's current status, the anticipated goal status, and the discharge status.

Mod	Modifier Description, Definition, Explanation, and Tips
CL	**At least 60 percent but less than 80 percent impaired, limited or restricted** **Definition:** Append modifier CL to a code for a patient with an impairment of 60 to 80 percent, with limited or restricted movement. **Explanation:** Modifier CL identifies the extent of impairment in a patient. The severity of impairment may range from 60 percent to 80 percent, with limited or restricted movement. CL is a severity modifier that a provider uses on specific therapy claims. Report only one functional limitation for each related therapy plan of care, or POC. In situations where a provider completes reporting on the first reportable functional limitation and the need for treatment continues, he reports a second functional limitation using another set of G codes. Functional reporting is necessary, at the beginning of a therapy episode of care, or on the date of service, or DOS, for the initial therapy service; at least once every ten treatment days; on the same DOS that a provider reports an evaluative or re evaluative on a claim; at the time of patient discharge from a therapy episode of care; and on the same DOS the reporting of a particular functional limitation ends, when further therapy is necessary. **Tips:** Use this modifier to report the severity or complexity for the functional measure for each non payable therapy G code. The severity modifiers reflect the patient's percentage of functional impairment as determined by the therapist, physician, or nonphysician practitioner who provides the therapy services. The appropriate severity modifiers report a patient's current status, the anticipated goal status, and the discharge status.
CM	**At least 80 percent but less than 100 percent impaired, limited or restricted** **Definition:** Append modifier CM to a code for a patient with an impairment of 80 to 100 percent, with limited or restricted movement. **Explanation:** Modifier CM identifies the extent of impairment in a patient. The severity of impairment may range from 80 percent to 100 percent, with limited or restricted movement. CM is a severity modifier that a provider uses on specific therapy claims. Report only one functional limitation for each related therapy plan of care, or POC. In situations where a provider completes reporting on the first reportable functional limitation and the need for treatment continues, he reports a second functional limitation using another set of G codes. Functional reporting is necessary, at the beginning of a therapy episode of care, or on the date of service, or DOS for the initial therapy service; at least once every ten treatment days; on the same DOS that a provider reports an evaluative or re evaluative on a claim; at the time of patient discharge from a therapy episode of care; and on the same DOS the reporting of a particular functional limitation ends, when further therapy is necessary. **Tips:** Use this modifier to report the severity or complexity for the functional measure for each non payable therapy G code. The severity modifiers reflect the patient's percentage of functional impairment as determined by the therapist, physician, or nonphysician practitioner who provides the therapy services. The appropriate severity modifiers report a patient's current status, the anticipated goal status, and the discharge status.
CN	**100 percent impaired, limited or restricted** **Definition:** Append modifier CN to a code for a patient with an impairment of 100 percent, with limited or restricted movement. **Explanation:** Modifier CN identifies the extent of impairment in a patient. The severity of impairment is 100 percent, with limited or restricted movement. CN is a severity modifier that a provider uses on specific therapy claims. Report only one functional limitation for each related therapy plan of care, or POC. In situations where a provider completes reporting on the first reportable functional limitation and the need for treatment continues, he reports a second functional limitation using another set of G codes. Functional reporting is necessary, at the beginning of a therapy episode of care, or on the date of service, or DOS, for the initial therapy service; at least once every ten treatment days; on the same DOS that a provider reports an evaluative or re evaluative on a claim; at the time of patient discharge from a therapy episode of care; and on the same DOS the reporting of a particular functional limitation ends, when further therapy is necessary. **Tips:** Use this modifier to report the severity or complexity for the functional measure for each non payable therapy G code. The severity modifiers reflect the patient's percentage of functional impairment as determined by the therapist, physician, or nonphysician practitioner who provides the therapy services. The appropriate severity modifiers report a patient's current status, the anticipated goal status, and the discharge status.

Mod	Modifier Description, Definition, Explanation, and Tips
CO	**Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant** **Definition:** Append modifier CO to codes for outpatient occupational therapy (OPT) when an OPT assistant performs all or a portion of the service. **Explanation:** Modifier CO denotes that some or all of a patient's outpatient occupational therapy (OPT) was performed by an OPT assistant. The OPT assistant performs the therapy in an outpatient setting, and the diagnosis code must be consistent with a condition that requires occupational therapy. OPT helps injured, ill, or disabled patients develop, recover, and improve skills needed for activities of daily living (ADLs),such as eating, bathing, dressing, toileting, and walking, and work-related activities, such as lifting, bending, sorting, and other skills depending on the type of work the patient performs. **Tips:** Append modifier CO only with codes on the list of applicable therapy services for occupational therapy and that are part of the plan of care for that patient.
CQ	**Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant** **Definition:** Append modifier CQ to codes for outpatient physical therapy (PT) when an PT assistant performs all or a portion of the service. **Explanation:** Modifier CQ denotes that some or all of a patient's outpatient physical therapy (PT) was performed by a PT assistant. The PT assistant performs the therapy in an outpatient setting, and the diagnosis code must be consistent with a condition that requires occupational therapy. Physical therapy uses therapeutic exercises and equipment to help patients with physical dysfunction regain or improve their physical abilities. **Tips:** Append modifier CQ only with codes on the list of applicable therapy services for physical therapy and that are part of the plan of care for that patient.
CR	**Catastrophe/disaster related** **Definition:** Append modifier CR to a code for services related to an emergency or disaster related condition. **Explanation:** Modifier CR identifies the services given to victims in the case of an emergency or disaster related condition such as a hurricane. In the event of a disaster or emergency, the Centers for Medicare and Medicaid Services, or CMS, issues specific guidance for use of this modifier. CMS provides information such as the geographic area the code is applicable to, and the beginning and end dates that apply to the use of the modifier and its related bill condition code, DR, Disaster related, which a provider also reports to identify the services are or may be impacted by specific policies related to a national or regional disaster. **Tips:** Use this modifier to code for catastrophe, disaster or emergency claims. You may use CR modifier for institutional or non institutional billing. One may use this modifier in case of an emergency disaster related condition and there is a condition levied on the payment of Medicare.
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** **Definition:** Append modifier CS to indicate cost-sharing is waived for specified COVID-19 testing-related services. Rural health clinics and federally qualified health centers also use modifier CS to distinguish telehealth services that have cost-sharing waived during the COVID-19 public health emergency. **Explanation:** Modifier CS is appropriate with codes for specified COVID-19 test-related services, including applicable telehealth services, if those services meet certain requirements for waiving cost-sharing. Examples of requirements include codes for evaluation and management (E/M) services that result in an order for, or administration of, a COVID-19 lab test during the public health emergency. **Tips:** Payer rules may vary for use of this modifier. Medicare states cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that are furnished between March 18, 2020, and the end of the COVID-19 public health emergency (PHE); result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the following E/M categories: office and other outpatient services; hospital observation services; emergency department services; nursing facility services; domiciliary, rest home, or custodial care services; home services; and online digital evaluation and management services. Medicare provides lists of codes that modifier CS may apply to. For Medicare, cost-sharing does not apply to the specified medical visit services for which payment is made to hospital outpatient departments paid under the Outpatient Prospective Payment System (OPPS), physicians and other professionals under the Physician Fee Schedule, Critical Access Hospitals (CAHs), RHCs, and FQHCs. RHCs and FQHCs append CS to G2025 (Distant site telehealth services Rural Health Clinics or Federally Qualified Health Centers (RHC/FQHC)) when the code represents one of the services where coinsurance is waived. Providers who use modifier CS should not charge patients co-insurance and/or deductible amounts for those services.

Mod	Modifier Description, Definition, Explanation, and Tips
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** **Definition:** Append modifier CT when a provider renders computed tomography (CT) with equipment that doesn't meet the National Electrical Manufacturers' Association standard. **Explanation:** The National Electrical Manufacturers' Association (NEMA) represents U.S. electrical equipment and medical imaging manufacturers. These manufacturers produce products that generate and transmit electricity and can be used for medical, commercial, and industrial purposes. Modifier CT appended to a code indicates that CT equipment was used for the patient's services, but that equipment does not comply with NEMA standards.
DA	**Oral health assessment by a licensed health professional other than a dentist** Summary: Append modifier DA to a code for an oral health assessment that a licensed health professional, other than a dentist, performs. **Explanation:** Modifier DA identifies an oral health assessment for a patient with dental or oral health problems. A licensed health professional other than a dentist performs this assessment. An oral health assessment determines the level of a patient's oral hygiene such as healthy or unhealthy oral cleanliness, condition of the lips, tongue, saliva, gums and tissue, and caries risk, meaning the patient's risk of tooth decay. **Tips:** This modifier is informational only and may be submitted with any appropriate HCPCS code.
E1	**Upper left, eyelid** **Definition:** Append modifier E1 when the provider performs a procedure on the left upper eyelid of a patient. **Explanation:** Modifier E1 illustrates a procedure that the provider performs on a patient's left upper eyelid. A provider uses modifier E1 to identify the left upper eyelid, instead of using modifier LT, Left side, which identifies a procedure the provider performs on the left side of the body. HCPCS level II modifiers apply to codes for procedures that the provider performs on paired organs, like eyelids, fingers, or toes. These modifiers help to prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body. **Tips:** If more than one modifier needs to be applied, you may need to repeat the HCPCS code on another line with the appropriate Level II modifier. When modifier E1 applies to the service, use it before selecting modifiers LT, RT, or 59, Distinct procedural service.
E2	**Lower left, eyelid** **Definition:** Append modifier E2 when the provider performs a procedure on the left lower eyelid of a patient. **Explanation:** Modifier E2 illustrates a procedure that the provider performs on the patient's left lower eyelid. A provider uses modifier E2 to identify the left lower eyelid, instead of using modifier LT, Left side, which identifies a procedure the provider performs on the left side of the body. HCPCS level II modifiers apply to codes for procedures that the provider performs on paired organs, like eyelids, fingers, or toes. These modifiers help to prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body. **Tips:** If more than one modifier needs to be applied, you may need to repeat the HCPCS code on another line with the appropriate Level II modifier.
E3	**Upper right, eyelid** **Definition:** Append modifier E3 when the provider performs a procedure on the right upper eyelid of a patient. **Explanation:** Modifier E3 illustrates a procedure that the provider performs on the patient's right upper eyelid. A provider uses modifier E3 to identify the right upper eyelid, instead of using modifier RT, Right side, which identifies a procedure the provider performs on the right side of the body. HCPCS level II modifiers apply to codes for procedures that the provider performs on paired organs, like eyelids, fingers, or toes. These modifiers help to prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body. **Tips:** If more than one modifier needs to be applied, repeat the HCPCS code on another line with the appropriate Level II modifier.

Mod	Modifier Description, Definition, Explanation, and Tips
E4	**Lower right, eyelid** **Definition:** Append modifier E4 when the provider performs a procedure on the right lower eyelid of a patient. **Explanation:** Modifier E4 illustrates a procedure that the provider performs on the patient's right lower eyelid. A provider uses modifier E4 to identify the right lower eyelid, instead of using modifier RT, Right side, which identifies a procedure the provider performs on the right side of the body. HCPCS level II modifiers apply to codes for procedures that the provider performs on paired organs, like eyelids, fingers, or toes. These modifiers help to prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body. **Tips:** If more than one modifier needs to be applied, you may need to repeat the HCPCS code on another line with the appropriate Level II modifier.
EA	**Erythropoietic stimulating agent (ESA) administered to treat anemia due to anti-cancer chemotherapy** **Definition:** Append modifier EA when the provider administers an agent that stimulates red blood cell production. The provider administers an erythropoietic stimulating agent, or ESA to treat anemia, a condition of a lower than normal hemoglobin, or red blood cell count in the blood of a patient taking anti cancer chemical compounds or drugs. **Explanation:** Modifier EA depicts administration of erythropoietic stimulating agent, or ESA, to a patient who has taken or is taking anti cancer drugs. The provider administers ESA to enhance the stimulation of red blood cells to treat anemia or low hemoglobin. The medical record should justify the diagnosis that corresponds to the administration of ESA as well as the nature or extent of the anemia. **Tips:** If the provider administers ESA to treat anemia due to anticancer radiotherapy, append modifier EB, Erythropoietic stimulating agent or ESA administered to treat anemia due to anti cancer radiotherapy. If the provider administers ESA to treat anemia, not due to anti cancer radiotherapy or chemotherapy, append modifier EC, Erythropoietic stimulating agent or ESA, administered to treat anemia not due to anti cancer radiotherapy or anti cancer chemotherapy.
EB	**Erythropoietic stimulating agent (ESA) administered to treat anemia due to anti-cancer radiotherapy** **Definition:** Append modifier EB when the provider administers an agent that stimulates red blood cell production. The provider administers an erythropoietic stimulating agent, or ESA to treat anemia, a condition of a lower than normal hemoglobin, or red blood cells count in the blood of a patient taking anti cancer radiotherapy. **Explanation:** Modifier EB identifies administration of erythropoietic stimulating agent, or ESA, to a patient who has received or is receiving anti cancer radiotherapy. The provider administers ESA to enhance the stimulation of red blood cells to treat anemia or low hemoglobin. The medical record should justify the diagnosis that corresponds to the administration of ESA as well as the nature or extent of the anemia. **Tips:** If the provider administers ESA to treat anemia due to anticancer chemotherapy, append modifier EA, Erythropoietic stimulating agent or ESA administered to treat anemia due to anti cancer chemotherapy. If the provider administers ESA to treat anemia, not due to anti cancer radiotherapy or chemotherapy, append modifier EC, Erythropoietic stimulating agent or ESA administered to treat anemia not due to anti cancer radiotherapy or anti cancer chemotherapy.
EC	**Erythropoietic stimulating agent (ESA) administered to treat anemia not due to anti-cancer radiotherapy or anti-cancer chemotherapy** **Definition:** Append modifier EC when the provider administers an agent that stimulates red blood cell production. The provider administers an erythropoietic stimulating agent, or ESA to treat anemia, a condition of a lower than normal red blood cell count or hemoglobin in the blood of a patient. The anemia is not because of taking anti cancer chemotherapy or radiotherapy. **Explanation:** Modifier EC identifies administration of erythropoietic stimulating agent, or ESA, to a patient to enhance the stimulation of red blood cells to treat anemia or low hemoglobin. The medical record should justify the diagnosis that corresponds to the administration of ESA as well as the nature or extent of the anemia. Append this modifier when anemia does not develop due to anti cancer chemotherapy or radiotherapy. **Tips:** If the provider administers ESA to treat anemia due to anticancer chemotherapy, append modifier EA, Erythropoietic stimulating agent or ESA administered to treat anemia due to anti cancer chemotherapy. If the provider administers ESA to treat anemia due to anticancer radiotherapy, append modifier EB, Erythropoietic stimulating agent or ESA administered to treat anemia due to anti cancer radiotherapy.

Mod	Modifier Description, Definition, Explanation, and Tips
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** **Definition:** Append modifier ED to a code for hemodialysis patients when the provider measures the hematocrit level and it exceeds 39 percent or the hemoglobin level exceeds 13.0 g/dl, or grams per deciliter, for three or more consecutive billings immediately prior to and including the current service. **Explanation:** Modifier ED illustrates the measurement of a patient's hematocrit level which exceeds 39 percent or a hemoglobin level, which is greater than 13.0 g/dl, or grams per deciliter, in a patient undergoing hemodialysis for end stage renal disease, or ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. The provider tests the patient's hemoglobin level in hemodialysis patients. He tests for three or more consecutive billing cycles immediately prior to and including the current cycle and appends this modifier when applicable. **Tips:** Requests for payments or claims for ESAs for ESRD patients receiving dialysis in renal dialysis facilities must report modifiers ED or EE, Hematocrit level has not exceeded 39% or hemoglobin level has not exceeded 13.0 g per dl for three or more consecutive billing cycles immediately prior to and including the current cycle. Providers may continue to report modifier GS, Dosage of erythropoietin stimulating agent has been reduced and maintained in response to hematocrit or hemoglobin level, when the provider reports that the hematocrit or hemoglobin levels exceed the monitoring threshold and a dose reduction has occurred. When the GS modifier is on a claim also reporting modifier EE, the claim will be paid in full. The GS modifier, however, has no effect on the 50 percent dosage reduction, on claims reporting modifier ED.
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** **Definition:** Append modifier EE to a code for hemodialysis patients when the provider measures the hematocrit level which does not exceed 39 percent or the hemoglobin level does not exceed 13.0g/dl, or grams per deciliter, for three or more consecutive billings immediately prior to and including the current service. **Explanation:** Modifier EE illustrates the measurement of the hematocrit level which does not exceed 39 percent or a hemoglobin level, which is not greater than 13.0 g per dl, or grams per deciliter, in a patient undergoing hemodialysis for end stage renal disease, or ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. The provider tests the patient's hemoglobin level in hemodialysis patients. He tests for three or more consecutive billing cycles immediately prior to and including the current cycle and appends this modifier when applicable. **Tips:** Requests for payments or claims for ESAs for ESRD patients must report modifiers ED, Hematocrit level has exceeded 39% or hemoglobin level has exceeded 13.0 g per dl for three or more consecutive billing cycles immediately prior to and including the current cycle, or append modifier EE. Providers may continue to report the modifier GS, Dosage of erythropoietin stimulating agent has been reduced and maintained in response to hematocrit or hemoglobin level, when the hematocrit or hemoglobin levels that the provider reports exceed the monitoring threshold and a dose reduction has occurred. When the GS modifier is on a claim also reporting modifier EE, the claim will be paid in full. The GS modifier, however, has no effect on the 50 percent dosage reduction, on claims reporting modifier ED.
EJ	**Subsequent claims for a defined course of therapy, e.g., EPO, sodium hyaluronate, infliximab** **Definition:** Append modifier EJ to a code for subsequent claims for a defined course of EPO, sodium hyaluronate, or infliximab therapy for a patient. **Explanation:** Modifier EJ illustrates the coding of subsequent claims for a defined course of therapy for a patient. The therapy may include EPO, or erythropoietin therapy, a growth factor that stimulates the production of red blood cells; sodium hyaluronate, a substance similar to a joints own natural protection that acts like a lubricant and or cushion when injected directly into a joint such as the knee; or infliximab, a manmade antibody given intravenously to treat various chronic inflammatory diseases. This modifier allows the easy identification of a subsequent claim, which does not require as much information as an initial claim and prevents unnecessary claim inquiries, letters, and questionnaires. One can submit subsequent claims electronically. **Tips:** Modifier EJ is an informational code for Medicare use. Because of this fact, submit this modifier in the last modifier position, after any other modifiers. The biller may also submit this modifier with many HCPCS J codes for injections.

Mod	Modifier Description, Definition, Explanation, and Tips
EM	**Emergency reserve supply (for ESRD benefit only)** **Definition:** Append modifier EM to a code for an emergency reserve supply of an erythropoiesis stimulating agent, or ESA, for hemodialysis patients with end stage renal disease, or ESRD. **Explanation:** Modifier EM illustrates the measurement of the emergency reserve supply for an ESA, or erythropoiesis stimulating agent in a patient undergoing hemodialysis for end stage renal disease, or ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. The provider tests the patient's blood to ensure that the dialysis is removing the waste products effectively. Use this code for ESRD patients beginning to self administer an ESA, or erythropoiesis stimulating agents, at home for the treatment of anemia due to the disease and who receive an extra month supply of the drug, this one month reserve supply is reportable on the claim line with modifier EM. **Tips:** Providers most commonly append this modifier to 90999, Unlisted dialysis procedure, inpatient or outpatient. It is not necessary to use the modifier on every claim line, but facilities should be sure to include the modifier on at least one revenue code claim line for Medicare. The modifier can affect the processing of the payment of the code.
EP	**Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program** **Definition:** Append modifier EP to a code for a service that the provider gives as part of the Medicaid early periodic screening diagnosis and treatment, or EPSDT program. **Explanation:** Modifier EP illustrates billing of the service that the provider delivers as part of the Medicaid early periodic screening diagnosis and treatment, or EPSDT, program. This includes preventive health checkups and treatments to children from birth to young adults. A few of the types of early preventative health screening and treatments include immunization, administration and health screenings for hearing and vision problems. Modifier EP can be appended to several of the immunization administration codes, and preventive medicine, periodic and interperiodic assessments. **Tips:** Only providers delivering EPSDT medical services should use the EP modifier code for billing purposes. The claim form must contain the procedure code to represent the type of medical service that the provider gives along with the EP modifier to show this was an early preventative service office visit.
ER	**Items and services furnished by a provider-based, off-campus emergency department** **Definition:** Append modifier ER to codes for outpatient hospital services and items, such as drugs or bandages, furnished in an off-campus provider-based emergency department (ED). **Explanation:** Modifier ER denotes that an item or outpatient hospital service was provided by an off-campus provider-based emergency department. Off campus means a location physically separate from the immediate area of the hospital facility and or in a building located more than 250 yards away from the main hospital buildings. **Tips:** Critical access hospitals are not required to append this modifier. Modifier ER is used for informational purposes at its institution in 2019 and does not impact payment, but like other modifiers previously introduced for tracking outpatient services provided in other off-campus provider-based departments (PBDs), it may at some point affect payment. Individual providers should not append modifier ER and instead should use the appropriate place of service code to indicate outpatient services furnished in an on-campus, remote, or satellite location of a hospital or in an off-campus, provider-based hospital setting.
ET	**Emergency services** **Definition:** Append modifier ET to a code for the emergency services, including hospital emergency services, for multiple service dates, where the ER encounter spans more than one service date. **Explanation:** Modifier ET illustrates billing for the hospital emergency room, or ER, services when the provider delivers emergency services to a patient in that setting. This includes emergency department services for multiple service dates. ER services that a patient receives in a hospital are excluded from SNF Consolidated Billing, or SNF CB, for beneficiaries that are in a skilled Part A SNF stay. This code flags the service to bypass SNF Consolidated Billing, or CB, claim edits for the ER related service line items identified by the modifier ET. This code is not applicable for the services a patient receives in the Part A skilled nursing facility, or SNF. Append modifier ET with codes such as 99070, 99218, 99281 to 99285, and 99291 and 99292. **Tips:** Append modifier ET every time the patient visits the hospital emergency room, or ER. The services given in a hospital emergency room excludes the skilled nursing facility care. The service extends to multiple dates of service. Append this modifier to a code for an emergency dental procedures as well.
EX	**Expatriate beneficiary** **Definition:** This modifier designates a non-U.S. citizen working in his home country. **Explanation:** The Centers for Medicare and Medicaid Services (CMS) identify expatriates as insureds who are non-U.S. citizens working in their home country.

Mod	Modifier Description, Definition, Explanation, and Tips
EY	**No physician or other licensed healthcare provider order for this item or service** **Definition:** Append modifier EY to items or services without an order or prescription from the treating provider. This informational modifier notifies insurer that the provider is requesting a denial for secondary billing. For Medicare this is under the Coordination of Benefit, or COB guidelines. A provider appends this code when they issue durable medical equipment, prosthetic and orthotic supplies, or DMEPOS, without an order. **Explanation:** For Coordination of Benefit, or COB, purposes, the suppliers use the modifier EY, No licensed healthcare provider order for this item or service, on each line item on the claim and report their own name and National Provider Identifier, or NPI, as the ordering or referring provider. This is done to obtain a Medicare denial, under COB guidelines, which is where two or more insurances work together to pay for a service when a patient has more than one health insurance plan. Failure to include the EY modifier with all codes results in the return of the claim as unprocessable. If a provider has an order for some, but not all, of the items or services the provider furnishes to the Medicare beneficiary, the provider submits a separate claim for the items the provider dispenses to the patient without the treating physician's order. **Tips:** Medicare coverage requires an order by the provider, with the exception of some preventive screenings, or else the service is denied.
F1	**Left hand, second digit** **Definition:** Append modifier F1 when the provider performs a procedure on the second digit, or finger, of the left hand. **Explanation:** Modifier F1 identifies a procedure that the provider performs on the second, or index, finger of the left hand. This modifier is appropriate for surgical and diagnostic services but is not appropriate for Evaluation and Management, or E/M services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
F2	**Left hand, third digit** **Definition:** Append modifier F2 when the provider performs a procedure on the third digit, or finger of the left hand. **Explanation:** Modifier F2 illustrates a procedure that the provider performs on the third digit of the left hand. This modifier is appropriate for surgical and diagnostic services but is not appropriate for Evaluation and Management, or E/M services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
F3	**Left hand, fourth digit** **Definition:** Append modifier F3 when the provider performs a procedure on the fourth digit, or finger, of the left hand. **Explanation:** Modifier F3 illustrates a procedure that the provider performs on the fourth finger of the left hand. This modifier is appropriate for surgical and diagnostic services but not appropriate for Evaluation and Management, or E/M services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.

Mod	Modifier Description, Definition, Explanation, and Tips
F4	**Left hand, fifth digit** **Definition:** Append modifier F4 when the provider performs a procedure on the fifth digit, or finger of the left hand. **Explanation:** Modifier F4 illustrates a procedure that the provider performs on the fifth finger of the left hand. This modifier is applicable usually to surgical and diagnostic services but not appropriate for Evaluation and Management, or EM, services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
F5	**Right hand, thumb** **Definition:** Append modifier F5 when the provider performs a procedure on the thumb of the right hand. **Explanation:** Modifier F5 illustrates a procedure that the provider performs on the thumb of the right hand. This modifier is appropriate for surgical and diagnostic services but not appropriate for Evaluation and management, or E/M, services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
F6	**Right hand, second digit** **Definition:** Append modifier F6 when the provider performs a procedure on the second digit, or finger, of the right hand. **Explanation:** Modifier F6 illustrates a procedure that the provider performs on the second finger of the right hand. This modifier is appropriate for surgical and diagnostic services but not appropriate for Evaluation and Management, or E/M services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
F7	**Right hand, third digit** **Definition:** Append modifier F7 when the provider performs a procedure on the third digit, or finger, of the right hand. **Explanation:** Modifier F7 illustrates a procedure that the provider performs on the third finger of the right hand. This modifier is appropriate for surgical and diagnostic services but not appropriate for Evaluation and Management, or E/M services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
F8	**Right hand, fourth digit** **Definition:** Append modifier F8 when the provider performs a procedure on the fourth digit, or finger, of the right hand. **Explanation:** Modifier F8 illustrates a procedure that the provider performs on the fourth digit of the right hand. This modifier is appropriate for surgical and diagnostic services but not appropriate for Evaluation and Management, or E/M services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.

Mod	Modifier Description, Definition, Explanation, and Tips
F9	**Right hand, fifth digit** **Definition:** Append modifier F9 when the provider performs a procedure on the fifth digit, or finger, of the right hand. **Explanation:** Modifier F9 illustrates a procedure that the provider performs on the fifth digit of the right hand. This modifier is appropriate for surgical and diagnostic services but not appropriate for Evaluation and Management, or E/M services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
FA	**Left hand, thumb** **Definition:** Append modifier FA when the provider performs a procedure on the thumb of the left hand. **Explanation:** Modifier FA illustrates a procedure that the provider performs on the thumb of the left hand. This modifier is appropriate for surgical and diagnostic services but not appropriate for Evaluation and Management, or E/M, services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
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)** **Definition:** Append modifier FB with the facility charge for a surgery when a provider furnishes a device at no cost or when there is a full credit for a replacement device. This modifier triggers a reduced Ambulatory Payment Classification, or APC, payment when a provider reports the code on claims subject to the outpatient prospective payment system, or OPPS. **Explanation:** Modifier FB identifies the replacement of an implanted item or device with a device for which the provider incurs no cost or when the provider replaces an implanted device with a device for which they receive a full credit in the amount of the cost of the replaced device. Modifier FB may extend to nuclear medicine procedures when the provider obtains the associated diagnostic radiopharmaceutical at no cost. Append this modifier only when the supplier or provider makes the item available without cost or the facility receives an entire credit for the cost of the item. Always append modifier FB to the surgical procedure code, and not the item code. If the provider reports the modifier with the device code instead of the procedure code, the entire claim will be returned. **Tips:** Report modifier FC when the facility does not receive full credit for the cost of the item but receives a partial credit for the replaced device.
FC	**Partial credit received for replaced device** **Definition:** Append modifier FC when a facility furnishes a device and does not incur the full cost of the device such as when the provider receives a manufacturer credit of 50 percent or more of the cost of the device. **Explanation:** Modifier FC identifies that the provider receives a partial credit of 50 percent or more of the cost of a device for a replaced device. A provider appends this modifier for a new replacement device where the provider receives a discount of at least half or more of the cost of an item such as those under warranty, recall, or field action. Always append modifier FB to the surgical procedure code, and not the item code. At the time of device replacement, the provider may not know the amount of credit the manufacturer will provide for the device, or whether he will provide any discount at all. The facility has the option of either submitting the claim immediately without the FC modifier, or submitting a claim adjustment with the FC modifier at a later date once the credit determination is made. Or the facility may hold the claim until it is sure of the status of the credit. **Tips:** Medicare reduces their payment by 50 percent of the estimated cost of the device included in the procedure payment in cases in which the facility reports that it receives a credit of 50 percent or more of the cost of the new replacement device by appending the FC modifier to the device implantation procedure HCPCS code.

Mod	Modifier Description, Definition, Explanation, and Tips
FP	**Service provided as part of family planning program** **Definition:** Append modifier FP to a code when reporting an annual family planning examination. **Explanation:** Modifier FP identifies that the services the provider furnishes is part of a family planning program. As a rule, providers append modifier FP only when reporting for the annual family planning examination. The provider reports the FP modifier with the code he reports for the family planning service. **Tips:** A provider omits modifier FP when reporting for all other family planning services, such as evaluation and management services, laboratory services, and anesthesia services.
FQ	**The service was furnished using audio-only communication technology** **Definition:** Append modifier FQ to indicate a service rendered to a patient used audio–only technology. The technology allows for two–way, real–time communication. **Explanation:** Modifier FQ indicates the provider rendered a healthcare service using an audio–only communication technology. The technology allows the patient and provider to communicate in real time. An example is a telephone call using sound without video visualization of the patient. This may occur when the patient is unable to use, does not wish to use, or does not have access to two–way, audio/video technology. **Tips:** See payer guidelines regarding services that are eligible for modifier FQ. An example may be treatment of a patient with a mental health condition who is calling the provider from home.
FR	**The supervising practitioner was present through two-way, audio/video communication technology** **Definition:** Append modifier FR to indicate the provider supervising the service was present through two–way communication technology with both audio and video. **Explanation:** Modifier FR indicates that the provider supervising the healthcare service was present virtually via technology rather than being physically present. The technology must allow two–way communication and must include both audio and video. **Tips:** See payer guidelines regarding services that are eligible for modifier FR.
FS	**Split (or shared) evaluation and management visit** **Definition:** Append modifier FS to indicate the service was a split or shared evaluation and management (E/M) visit. **Explanation:** Modifier FS indicates that an evaluation and management (E/M) service meets the definition of a split or shared visit. This modifier was created for Medicare use, but other payers may accept it. For Medicare, a split or shared service is an E/M service in a facility setting performed in part by a physician and in part by a nonphysician practitioner (NPP) in the same group, in accordance with applicable guidelines and regulations. **Tips:** See payer guidelines regarding services that are eligible for modifier FS. For instance, follow Medicare's definition of a split or shared visit when reporting to Medicare. Other payers may not accept this modifier or may not use Medicare's definition of a split or shared visit.
FT	**Unrelated evaluation and management (e/m) visit on the same day as another e/m visit or during a global procedure (preoperative, postoperative period, or on the same day as the procedure, as applicable). (report when an e/m visit is furnished within the global period but is unrelated, or when one or more additional e/m visits furnished on the same day are unrelated)** **Definition:** Append modifier FT to report an unrelated evaluation and management (E/M) service during the postoperative period of a procedure or on the same day of another E/M service. **Explanation:** Modifier FT indicates that an evaluation and management (E/M) service performed during a postoperative period is not related to the operative procedure. Alternatively, appending the modifier may indicate that an E/M service is unrelated to a procedure performed on the same date or that the E/M is unrelated to another E/M on the same date. **Tips:** See payer guidelines regarding services that are eligible for modifier FT. For instance, a payer may indicate the modifier is appropriate for a critical care E/M service code.
FX	**X-ray taken using film** **Definition:** Append modifier FX to a radiology code to indicate that an X-ray is film. **Explanation:** Modifier FX indicates that the provider took an X-ray using film, as opposed to digital radiography, which uses digital X-ray sensors to produce an X-ray image. **Tips:** Append modifier FY to a radiology code to indicate that an X–ray was performed using cassette–based (film) imaging. For any radiology service, be sure to determine if you need to append other modifiers to the radiology code, such as modifiers LT (left), RT (right), 50 (bilateral), 26 (professional component), or TC (technical component). The circumstances of each encounter will dictate appropriate modifier usage, along with each payer's requirements. Be sure to check specific payer guidelines for acceptable modifiers.

Mod	Modifier Description, Definition, Explanation, and Tips
FY	**X-ray taken using computed radiography technology/cassette-based imaging** **Definition:** Append modifier FY to a radiology code to indicate that a digital image was created using cassette-based imaging, such as a phosphor imaging plate (IP), rather than conventional film. **Explanation:** Providers are required to append modifier FY to a radiology code when the imaging involves cassette-based imaging. Medicare payments for cassette-based imaging are reduced by 7% until 2023 and 10% thereafter. The imaging plate is reusable and requires no chemicals or darkroom. Cassette-based imaging involves using an imaging plate that has a phosphorus layer which, when exposed to X-ray or gamma radiation, captures and stores the image. The plate is placed in a scanner, and the image is released when a laser beam is focused on the plate. The image data is converted into electrical signals which are digitized and displaced on a monitor for the radiologist to read (interpret) the image. The digitized image can be saved like any digital file, and the plate is erased to be reused. **Tips:** Append modifier FY to a radiology code to indicate that imaging was performed using a phosphor imaging plate or cassette-based imaging. For any radiology service, be sure to determine if you need to append other modifiers to the radiology code, such as modifiers LT (left), RT (right), 50 (bilateral), 26 (professional component), or TC (technical component). The circumstances of each encounter will dictate appropriate modifier usage, along with each payer's requirements. Be sure to check specific payer guidelines for acceptable modifiers.
G0	**Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke** **Definition:** Append modifier G0 (G-zero) to codes for diagnosis, evaluation, or treatment of an acute stroke via an audio or video telecommunications system. **Explanation:** Modifier G0 (G-zero) denotes that a provider diagnosed, evaluated, or treated a patient for an acute stroke remotely using an audio and/or video telecommunication system. **Tips:** CMS removed restrictions on geographic locations and types of sites where acute stroke telehealth services can be furnished, so telehealth services for acute stroke may be provided to patients in both rural and urban areas. In addition, mobile stroke units may qualify as originating sites for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. Whether an ambulance equipped with an audio and/or video telecommunication system qualifies as a mobile stroke unit is uncertain. Check with CMS and payers if uncertain that a code qualifies for this modifier.
G1	**Most recent URR reading of less than 60** **Definition:** Append modifier G1 to a code for a hemodialysis patient when the provider measures the urea reduction ratio, or URR, and the reading is less than 60. **Explanation:** Modifier G1 illustrates the measurement of the urea reduction ratio, or URR, in a patient undergoing hemodialysis for end stage renal disease, or ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. The provider tests the patient's blood to ensure that the dialysis is removing the waste products effectively. The provider takes two blood samples, one at the beginning of treatment and the second at the end of dialysis, and compares them. Any reduction in urea due to dialysis is known as the urea reduction ratio, or URR. Use G1 to report a reading of less than 60. Providers most commonly append this modifier to 90999, Unlisted dialysis procedure, inpatient or outpatient. It is not necessary to use the modifier on every code, but facilities should be sure to include the modifier on at least one claim line for Medicare. The modifier can affect the processing of the payment of the code. **Tips:** Select the proper modifier from G1 to G5 based on the reading. When using modifier G1, you should remember that the provider measures the ratio of urea reduction in a patient undergoing hemodialysis, and the reading is less than 60. Watch situations where G1 to G5 are not applicable because of the number of dialysis sessions. For example, when modifier G6, ESRD patient for whom less than six dialysis sessions have been provided in a month, applies for Medicare claims instead of the G1 to G5 modifiers due to the number of patient dialysis sessions. Medicare requires all hemodialysis claims to show the most recent urea reduction ratio for a patient undergoing dialysis. The dialysis facility should monitor the URR monthly in patients who are admitted in the facility. Monitoring of URR in home patients should take place at least quarterly.

Mod	Modifier Description, Definition, Explanation, and Tips
G2	**Most recent URR reading of 60 to 64.9** **Definition:** Append modifier G2 to a code for hemodialysis patients when the provider measures the urea reduction ratio and the reading is 60 to 64.9. **Explanation:** Modifier G2 illustrates the measurement of urea reduction ratio, or URR, in a patient undergoing hemodialysis for end stage renal disease, called ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. The provider tests the patient's blood to ensure that the dialysis is removing the waste products effectively. The provider takes two blood samples, one at the beginning and the second at the end of dialysis, and compares them. Any reduction in urea due to dialysis is known as urea reduction ratio, URR. Use G2 for a reading of 60 to 64.9. **Tips:** Select the proper modifier from G1 to G5 based on the reading. When using modifier G2, you should remember that the provider measures the ratio of urea reduction in a patient undergoing hemodialysis, and the reading ranges from 60 to 64.9. Watch for when G6, ESRD patient for whom less than six dialysis sessions have been provided in a month, applies for Medicare claims instead of G1 to G5 based on the number of dialysis sessions. Medicare requires all hemodialysis claims to show the most recent urea reduction ratio for a patient undergoing dialysis. The dialysis facility should monitor the URR monthly in patients who are admitted in the facility. Monitoring of URR in home patients should take place at least quarterly. Providers most commonly append this modifier to 90999, Unlisted dialysis procedure, inpatient or outpatient. It is not necessary to use the modifier on every claim line, but facilities should be sure to include the modifier on at least one revenue code claim line for Medicare. The modifier can affect the processing of the payment of the code.
G3	**Most recent URR reading of 65 to 69.9** **Definition:** Append modifier G3 to a code for hemodialysis patients when the provider measures the urea reduction ratio and the reading is 65 to 69.9. **Explanation:** Modifier G3 illustrates the measurement of urea reduction ratio, or URR, in a patient undergoing hemodialysis for end stage renal disease, called ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. The provider tests the patient's blood to ensure that the dialysis is removing the waste products effectively. The provider takes two blood samples, one at the beginning and the second at the end of dialysis, and compares them. Any reduction in urea due to dialysis is known as urea reduction ratio, URR. Use G3 for a reading of 65 to 69.9. **Tips:** Select the proper modifier from G1 to G5 based on the reading. When using modifier G3, you should remember that the provider measures the ratio of urea reduction in a patient undergoing hemodialysis, and the reading ranges from 65 to 65.9. Watch for when G6, ESRD patient for whom less than six dialysis sessions have been provided in a month, applies for Medicare claims instead of G1 to G5 based on the number of dialysis sessions. Medicare requires all hemodialysis claims to show the most recent urea reduction ratio for a patient undergoing dialysis. The dialysis facility should monitor the URR monthly in patients who are admitted in the facility. Monitoring of URR in home patients should take place at least quarterly. Providers most commonly append this modifier to 90999, Unlisted dialysis procedure, inpatient or outpatient. It is not necessary to use the modifier on every claim line, but facilities should be sure to include the modifier on at least one revenue code claim line for Medicare. The modifier can affect the processing of the payment of the code.

Mod	Modifier Description, Definition, Explanation, and Tips
G4	**Most recent URR reading of 70 to 74.9** **Definition:** Append modifier G4 to a code for hemodialysis patients when the provider measures the urea reduction ratio and the reading is 70 to 74.9. **Explanation:** Modifier G4 illustrates the measurement of urea reduction ratio, or URR, in a patient undergoing hemodialysis for end stage renal disease, called ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. The provider tests the patient's blood to ensure that the dialysis is removing the waste products effectively. The provider takes two blood samples, one at the beginning and the second at the end of dialysis, and compares them. Any reduction in urea due to dialysis is known as urea reduction ratio, URR. Use G4 for a reading of 70 to 74.9. **Tips:** Select the proper modifier from G1 to G5 based on the reading. When using modifier G4, you should remember that the provider measures the ratio of urea reduction in a patient undergoing hemodialysis, and the reading ranges from 70 to 74.9. Watch for when G6, ESRD patient for whom less than six dialysis sessions have been provided in a month, applies for Medicare claims instead of G1 to G5 based on the number of dialysis sessions. Medicare requires all hemodialysis claims to show the most recent urea reduction ratio for a patient undergoing dialysis. The dialysis facility should monitor the URR monthly in patients who are admitted in the facility. Monitoring of URR in home patients should take place at least quarterly. Providers most commonly append this modifier to 90999, Unlisted dialysis procedure, inpatient or outpatient. It is not necessary to use the modifier on every claim line, but facilities should be sure to include the modifier on at least one revenue code claim line for Medicare. The modifier can affect the processing of the payment of the code.
G5	**Most recent URR reading of 75 or greater** **Definition:** Append modifier G5 to a code for hemodialysis patients when the provider measures the urea reduction ratio and the reading is greater than 75. **Explanation:** Modifier G5 illustrates the measurement of urea reduction ratio, or URR, in a patient undergoing hemodialysis for end stage renal disease, called ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. The provider tests the patient's blood to ensure that the dialysis is removing the waste products effectively. The provider takes two blood samples, one at the beginning and the second at the end of dialysis, and compares them. Any reduction in urea due to dialysis is known as urea reduction ratio, URR. Use G5 for a reading greater than 75. **Tips:** Select the proper modifier from G1 to G5 based on the reading. When using modifier G5, you should remember that the provider measures the ratio of urea reduction in a patient undergoing hemodialysis, and the reading is greater than 75. Watch for when G6, ESRD patient for whom less than six dialysis sessions have been provided in a month, applies for Medicare claims instead of G1 to G5 based on the number of dialysis sessions. Medicare requires all hemodialysis claims to show the most recent urea reduction ratio for a patient undergoing dialysis. The dialysis facility should monitor the URR monthly in patients who are admitted in the facility. Monitoring of URR in home patients should take place at least quarterly. Providers most commonly append this modifier to 90999, Unlisted dialysis procedure, inpatient or outpatient. It is not necessary to use the modifier on every claim line, but facilities should be sure to include the modifier on at least one revenue code claim line for Medicare. The modifier can affect the processing of the payment of the code.
G6	**ESRD patient for whom less than six dialysis sessions have been provided in a month** **Definition:** Append modifier G6 to a code to show that the patient has had fewer than six sessions of dialysis in a month. Use this modifier for patients with end stage renal disease, or ESRD. **Explanation:** Modifier G6 represents that a patient has undergone fewer than six sessions of dialysis in a month for ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. **Tips:** If the provider confirms the patient had dialysis on fewer than six days in a month, modifier G6 applies. Watch for when G6 applies for Medicare claims instead of G1 to G5 for urea reduction ratio based on the number of dialysis sessions. Medicare requires a modifier from G1 to G6 for all hemodialysis claims as part of data collection on the most recent urea reduction ratio for a patient undergoing dialysis. The dialysis facility should monitor the URR monthly in patients who are admitted in the facility. Monitoring of URR in home patients should take place at least quarterly. Providers most commonly append this modifier to 90999, Unlisted dialysis procedure, inpatient or outpatient. It is not necessary to use the modifier on every claim line, but facilities should be sure to include the modifier on at least one revenue code claim line for Medicare. The modifier can affect the processing of the payment of the code.

Mod	Modifier Description, Definition, Explanation, and Tips
G7	**Pregnancy resulted from rape or incest or pregnancy certified by physician as life threatening** **Definition:** Append modifier G7 to an abortion code in cases of pregnancy that result from rape or incest, or when the provider confirms the pregnancy is dangerous for the patient's life. **Explanation:** Modifier G7 represents pregnancy due to rape or incest, or pregnancy that may pose a threat to the woman's life for reasons such as illness or injury. Medicare covers abortions when the patient's life is in danger, and the medical documentation should justify that the pregnancy was a danger to the patient's life. Medicare also covers abortions in cases of rape or incest. **Tips:** Check payer requirements for the codes to which modifier G7 applies. Typical codes include induced abortion codes 59840 to 59857 and 59866, Multifetal pregnancy reduction. If the provider bills these codes without modifier G7, Medicare will not reimburse the claims. Medicare will not reimburse abortions unless the pregnancy is the result of rape or incest, or the pregnancy is life threatening due to patient illness or condition, which may be the result of the pregnancy.
G8	**Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure** **Definition:** Append modifier G8 when the provider performs monitored anesthesia care, called MAC, for a procedure that is deep complex, complicated, or distinctly invasive. **Explanation:** Modifier G8 depicts monitored anesthesia care, or MAC, for a patient undergoing an invasive and complex surgical procedure. The provider administers MAC during a diagnostic or therapeutic procedure. He regularly monitors the physiologic functions during the administration of MAC. The medical record should justify the diagnosis that corresponds to the administration of monitored anesthesia as well as the complex or particularly invasive nature of the surgical procedure. **Tips:** Payers may define the codes the provider may use this modifier with certain anesthesia codes. Examples may include only certain anesthesia codes, 00300, 00400, and 00920. Check payer policies for specific codes. Providers generally report G8 secondary to modifiers AA, Anesthesia services performed personally by anesthesiologist, and QX, CRNA service: with medical direction by a physician. You should not use modifier QS, Monitored anesthesia care service, along with G8 because the latter indicates that the provider has given MAC.
G9	**Monitored anesthesia care for patient who has history of severe cardio-pulmonary condition** **Definition:** Append modifier G9 when the provider performs monitored anesthesia care, called MAC, for a patient with a severe condition relating to the heart and lungs. **Explanation:** Modifier G9 depicts monitored anesthesia care, or MAC, for a patient who has a history of a severe cardiopulmonary condition. The provider administers MAC during a diagnostic or therapeutic procedure. He regularly monitors the physiologic functions during the administration of MAC. The medical record should justify the diagnosis that corresponds to the administration of monitored anesthesia as well as the nature of the cardiopulmonary condition. **Tips:** You should report this modifier with anesthesia codes when appropriate for the patient. Providers generally report G9 secondary to modifiers AA, Anesthesia service performed personally by anesthesiologist, and QX, CRNA service: with medical direction by a physician. You should not use modifier QS, Monitored anesthesia care service, along with G9 because the latter indicates that the provider has given MAC.
GA	**Waiver of liability statement issued as required by payer policy, individual case** **Definition:** Append modifier GA to a code when a payer requires the provider to present an advance beneficiary notice, or ABN, before the patient receives an item or service the provider expects Medicare not to cover. **Explanation:** The provider appends modifier GA to a code to indicate the patient's receipt of an advance beneficiary notice, or ABN, also known as a waiver of liability, for items or services for which the provider believes Medicare will not consider reasonable and necessary and thus deny payment. Medicare denial may involve services subject to a local coverage determination, or LCD, a denial based on the policies of a particular intermediary or carrier. The intent of the ABN is to inform the patient that Medicare certainly or most probably will not pay for an item or service and will assign financial responsibility to the patient for the charges. **Tips:** You can append modifier GA with a code even when the patient refuses to sign an ABN. Medicare prohibits the routine use of an ABN except for certain services that have a frequency limit on coverage.

Mod	Modifier Description, Definition, Explanation, and Tips
GB	**Claim being resubmitted for payment because it is no longer covered under a global payment demonstration** **Definition:** Append modifier GB to a code when the provider resubmits a claim for payment because a global payment demonstration, a type of bundling program, does not cover the service anymore. **Explanation:** Modifier GB identifies services for which a provider submits a claim under a global payment demonstration and later determines the patient or the service did not qualify for inclusion, so he resubmits the claim under the traditional fee for service program. Global payment demonstration projects reimburse a package price for a group of services based on the expected costs for an episode of care, as a combined quality improvement and cost reduction measure. The original claim may have been a no pay claim, one that identifies services or items for informational purposes without expectation of reimbursement. **Tips:** If another modifier defines the services more distinctly, use GB as the secondary modifier. Modifier GB is an informational modifier, and the provider may submit it with any HCPCS or CPT® code.
GC	**This service has been performed in part by a resident under the direction of a teaching physician** **Definition:** Append modifier GC to a code when a resident performs any portion of a service under the guidance of a teaching provider. **Explanation:** Modifier GC denotes that a resident, a medical graduate working in a teaching facility and under the supervision of a teaching provider, performs a billable service. The teaching provider must be present during the major part of the service and be readily available for other parts of the service. The medical record must include notes from both the resident and the teaching provider, with the teaching provider's notes commenting on the resident's documentation, attesting to the resident's findings, correcting or elaborating as necessary, also known as an attestation. Both the resident and the teaching provider must sign and date the documentation. **Tips:** Modifier GC is an informational modifier, and the provider may submit it with any CPT® or HCPCS code. A cosignature alone does not satisfy CMS guidelines for documenting the presence and extent of involvement of the teaching provider. You can report a service with modifier GC when the teaching provider assists the resident during an entire procedure and reexamines the patient after the procedure, as well. Medicare does not consider a lab pathologist as a teaching provider.
GE	**This service has been performed by a resident without the presence of a teaching physician under the primary care exception** **Definition:** Append modifier GE to a code when a resident sees a patient in an outpatient, or primary care, setting in the absence of a teaching provider. **Explanation:** Modifier GE denotes that the resident renders the services under Medicare's primary care exception rule, which reduces the restrictions on the physical presence requirement for teaching providers. Under certain conditions, Medicare will pay for the three lowest levels of Evaluation and Management, or E/M, services for outpatients seen by a resident without the presence of a teaching provider. The medical record has to demonstrate that the resident observes and appropriately documents the patient's present illness and physical examination and follows a plan of care. The resident must sign the medical documentation. Although the resident provides the E/M service in the absence of the teaching provider, the teaching provider reviews the patient's records and discusses the case with the resident.
GF	**Non-physician (e.g., 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** **Definition:** Append modifier GF to a code when a nonphysician provider performs a service in a critical access hospital. **Explanation:** Modifier GF denotes that a nonphysician provider, such as a nurse practitioner, certified registered nurse anesthetist, certified registered nurse, clinical nurse practitioner, or a physician assistant, renders a service in critical access hospital, a facility Medicare certifies under different conditions of participation in the Medicare program than an acute care facility. The nonphysician provider delivers the service in the absence of a physician provider. The medical record must show adequate documentation of the patient's present illness and physical examination and follow a plan of care. The nonphysician provider must sign the medical documentation. **Tips:** Modifier GF is an informational modifier, and the provider may submit it with any CPT® or HCPCS codes. Medicare reimburses 85 percent of the actual service charges to a nonphysician provider. The guidelines for reporting the services of a certified registered nurse anesthetist, or CRNA, may change, so check with your payer for specific information.

Mod	Modifier Description, Definition, Explanation, and Tips
GG	**Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day** **Definition:** Append modifier GG to a code when the provider performs two distinct mammograms, both screening and diagnostic, on a patient on the same date of service. **Explanation:** Modifier GG denotes that the provider performs screening mammography, an X-ray of the breast done for early detection of breast cancer, and during that exam detects an abnormality for which he performs diagnostic mammography on the same date of service to confirm the presence of cancer or any other defect. The provider does not require a separate order from the treating provider to perform the diagnostic mammography. **Tips:** If the provider converts a screening mammography to a diagnostic mammography but does not perform separate mammography exams, append to the relevant code modifier GH, Diagnostic mammogram converted from screening mammogram on same day. Medicare reimburses both screening and diagnostic mammography services as the modifier is for the purpose of discovering any abnormality in the breast. Medicare denies reimbursement for an add on code if the provider bills it without an appropriate mammography code. Both mammography codes with the appropriate add on code should appear on the same claim. Also, Medicare does not reimburse the service if the provider performs the second mammography only as a quality check or because of a system failure. If the screening services are self referred, the provider should give his own national provider identifier, or NPI, and not the referring provider's NPI for the service to be reimbursable. If the provider takes additional views on the same date of service because of the presence of an implant, payers may consider it as diagnostic views done on the same date. Payers may restrict the codes the provider may use with this modifier to certain mammography codes. Check payer policies for specific codes.
GH	**Diagnostic mammogram converted from screening mammogram on same day** **Definition:** Append modifier GH to a code when the provider performs a single mammogram that begins as a screening mammogram but converts it to a diagnostic mammogram. **Explanation:** Modifier GH denotes that the provider converts a screening mammography, an X-ray of the breast done for early detection of breast cancer, to a diagnostic mammography in a patient on the same date of service as a single exam This may occur if the patient presents for a screening mammogram due to an abnormality, and the provider changes the study from screening to diagnostic. The provider does not take any additional views during the exam. **Tips:** Append modifier GH to a single diagnostic mammography code. Medicare will pay for the diagnostic mammography only and not the screening mammography. If separate mammograms are performed on the same date of service, both screening and diagnostic, due to the discovery of an abnormality on a screening mammogram that requires further delineation, for example, report both exams and append modifier GG to the add on mammography code. Payers may restrict the use of this modifier to certain mammography codes. Check payer policies for specific codes.
GJ	**"Opt-out" physician or practitioner emergency or urgent service** **Definition:** Append modifier GJ to a code when a provider who has elected not to participate in the Medicare program renders services to a patient who presents with an emergency situation. **Explanation:** Modifier GJ denotes a service by a provider rendering emergency treatment to a Medicare patient and has no personal contract with the patient. The provider must submit the claim to Medicare on the patient's behalf and may not bill the patient more than Medicare's limiting charge. Medicare reimburses the patient directly for an unassigned claim. To submit an assigned claim, a provider can complete a CMS855 enrollment without impact on his opt out status for other services. The medical documentation must justify the emergency or urgent nature of the services to the patient. **Tips:** If the opt out provider asks the patient to return for a followup visit, he must ask the patient to sign a personal contract for these services in order to charge the patient for services Medicare will not pay. However, if the patient requires followup of the emergency care, Medicare would continue to pay until the time the patient no longer requires such care.

Mod	Modifier Description, Definition, Explanation, and Tips
GK	**Reasonable and necessary item/service associated with a GA or GZ modifier** **Definition:** Append modifier GK to a code, in addition to modifier GA or GZ, for upgrades to durable medical equipment, or DME, items or services that the provider deems medically necessary but exceed medical necessity under Medicare's coverage requirements. **Explanation:** The provider appends modifier GK to a code for an item or service associated with modifier GA, Carrier judgment Waiver of liability statement issued as required by payer policy, individual case, or GZ, Item or service expected to be denied as not reasonable and necessary, such as an upgrade to DME. If the provider expects to bill the patient for the difference in the cost, he presents an advance beneficiary notice, or ABN, to the patient and submits the claim with both modifiers. Medicare automatically denies the claim line with modifier GA on the basis of medical necessity but processes the claim line with modifier GK to allow the provider to bill the usual and customary fee for the upgraded items he supplies. Use modifier GZ in association with GK when an ABN is neither obtained nor required. **Tips:** If the provider doesn't intend to charge the patient for the difference in the cost of an upgrade, append modifier GL, Medically unnecessary upgrade provided instead of nonupgraded item, no charge, no advance beneficiary notice, or ABN. Do not use modifier GK for institutional claims that include the use of equipment and supplies, lab and radiology services, and other included items or services. You should append HCPCS modifiers in order on the claim, with GA or GZ before the use of GK. Always give a detailed description of the DME along with the manufacturer and the model number in the claim. Individual payers may specify use of modifier KX, Requirements specified in the medical policy have been met, along with modifier GK. Check with the payer to be sure. Medicare will reject a claim with modifier GK when modifier GA or GZ does not accompany it.
GL	**Medically unnecessary upgrade provided instead of non-upgraded item, no charge, no advance beneficiary notice (ABN)** **Definition:** Append modifier GL to a code for an upgrade to durable medical equipment, or DME, items that the provider deems medically necessary but exceed medical necessity under Medicare's coverage requirements. The provider does not charge the patient for the difference in cost and does not present an advance beneficiary notice, or ABN. **Explanation:** Modifier GL denotes that the provider upgrades a DME item but does not plan to charge the patient for the difference in the cost. The provider essentially bills Medicare for the cost of a nonupgraded item instead of the item he actually provides. The provider adds modifier GL to the HCPCS code that represents the nonupgraded item. **Tips:** Modifier GL does not require submission of an ABN. Individual payers may specify use of modifier KX, Requirements specified in the medical policy have been met, along with modifier GK. Check with the payer to be sure.
GM	**Multiple patients on one ambulance trip** **Definition:** Append modifier GM to a code for the transport of a patient by an ambulance that transports additional patients during the same trip. **Explanation:** Modifier GM denotes the situation in which an ambulance transports multiple patients during a single trip. The medical documentation must include the total number of patients and the particulars of each. The provider should submit the number of miles traveled by each patient along with the origin and destination modifier in the primary position and append modifier GM as the secondary modifier. **Tips:** You should append modifier GM only with ambulance transport claims. Append modifier GM even when only one of the transported patients is a Medicare beneficiary.
GN	**Services delivered under an outpatient speech language pathology plan of care** **Definition:** Append modifier GN to a code when the provider renders services that are part of a speech and language pathology plan of care for an outpatient. **Explanation:** Modifier GN denotes services that are part of an outpatient speech and language pathology plan of care. The provider carries out the service in an outpatient setting. The medical documentation must include a diagnosis code that indicates the patient is suffering from a speech disorder. **Tips:** Append modifier GN only with codes on the list of applicable therapy services for speech and language pathology and that are part of the plan of care for that patient. Medicare pays for services with modifier GN only when the patient receives these services as an outpatient.

Mod	Modifier Description, Definition, Explanation, and Tips
GO	**Services delivered under an outpatient occupational therapy plan of care** **Definition:** Append modifier GO to a code when the provider renders services that are part of an occupational therapy plan of care for an outpatient. **Explanation:** Modifier GO denotes services that are part of an outpatient occupational therapy plan of care. The provider carries out the service in an outpatient setting. The medical documentation must include a diagnosis code that is consistent with a condition that requires occupational therapy. **Tips:** Append modifier GO only with codes on the list of applicable therapy services for occupational therapy and that are part of the plan of care for that patient. Medicare pays for services with modifier GO only when the patient receives these services as an outpatient.
GP	**Services delivered under an outpatient physical therapy plan of care** **Definition:** Append modifier GP to a code when the provider renders services that are part of a physical therapy plan of care for an outpatient. **Explanation:** Modifier GP denotes services that are part of an outpatient physical therapy plan of care. The provider carries out the service in an outpatient setting. The medical documentation must include a diagnosis code that is consistent with a condition that requires physical therapy. **Tips:** Append modifier GP only with codes on the list of applicable therapy services for physical therapy and that are part of the plan of care for that patient. Medicare pays for services with modifier GP only when the patient receives these services as an outpatient.
GQ	**Via asynchronous telecommunications system** **Definition:** Append modifier GQ for services rendered to a patient via an asynchronous telecommunications system, one that does not involve live two way communication. **Explanation:** Modifier GQ denotes healthcare services provided via an asynchronous communication method. Asynchronous communication does not take place in real time. An example of delivery of a service via asynchronous communication includes a provider at a distant location, even in another state, who receives X-ray images transmitted across a secure network and then transmits the report of his reading of the images for later review by the patient's primary care provider. An exchange of email between a patient and a provider also constitute asynchronous telecommunication services. **Tips:** See payer guidelines for specific codes that require or are eligible for the GQ modifier.
GR	**This service was performed in whole or in part by a resident in a department of veterans affairs medical Centers or clinic, supervised in accordance with VA policy** **Definition:** Append modifier GR to codes for services rendered to a patient by a resident provider in a Veterans Administration, or VA, facility. **Explanation:** Modifier GR denotes services rendered in a VA facility by a resident provider, a medical graduate working under the supervision of an attending provider. The VA facility appends modifier GR to the appropriate HCPCS code for the service and submits the claim under the name of the attending provider. **Tips:** Modifier GR on VA claims has the same consequences as modifier GC, This service has been performed in part by a resident under the direction of a teaching physician, and modifier GE, This service has been performed by a resident without the presence of a teaching physician under the primary care exception. VA claims do not use modifier GC, This service has been performed in part by a resident under the direction of a teaching physician, or modifier GE, This service has been performed by a resident without the presence of a teaching physician under the primary care exception modifiers.
GS	**Dosage of erythropoietin stimulating agent has been reduced and maintained in response to hematocrit or hemoglobin level** **Definition:** Append modifier GS to a code when the provider reduces and maintains the dosage of erythropoietin, a hormone that stimulates the production of red blood cells, in response to an elevation in the level of hematocrit or hemoglobin in a patient with anemia of chronic kidney disease. **Explanation:** Modifier QS denotes a reduction in the dose of erythropoietin, or EPO, in response to an elevation in hematocrit, which measures the volume of red blood cells, or hemoglobin, which measures the amount of hemoglobin, a protein in red blood cells, for the treatment of anemia of chronic kidney disease. Medicare closely monitors the administration of erythropoietin stimulating agents, or ESAs, which at higher levels than necessary are ineffective and lead to complications, such as blood clots. **Tips:** Payers may designate only specific codes the provider may use with this modifier, such as injection codes J0881, J0882, J0885, and Q4081. Check payer policies for specific codes. Reimbursement depends upon the dosage reported, but Medicare automatically reduces reimbursement by 25 percent if the provider submits the claim without modifier GS.

Mod	Modifier Description, Definition, Explanation, and Tips
GT	**Via interactive audio and video telecommunication systems** **Definition:** Append modifier GT for telehealth, the use of an interactive audio and video communication system between a distant provider and the patient to execute a plan of care. **Explanation:** Modifier GT denotes a telehealth system, real time audiovisual conferencing between a patient and provider, in which a provider at a distant site provides healthcare services for a patient at a different location, including an examination. The patient must be an active participant in a telehealth visit, but it is not necessary for the provider to personally perform all portions of a telehealth service, as his clinical staff may provide some services. **Tips:** Check payer policy to determine whether the payer allows use of modifier GT. For instance, the payer may limit use of the modifier to certain settings.
GU	**Waiver of liability statement issued as required by payer policy, routine notice** **Definition:** Append modifier GU to a code when a payer requires the provider to present an advance beneficiary notice, or ABN, as a routine notice before the patient receives an item or service the provider expects Medicare not to cover. **Explanation:** Modifier GU indicates the patient's receipt of an advance beneficiary notice, or ABN, also known as a waiver of liability, as a routine notice for items or services that the provider believes Medicare will not consider reasonable and necessary and thus deny payment. The intent of the ABN is to inform the patient that Medicare certainly or most probably will not pay for an item or service and will assign financial responsibility to the patient for the charges. Medicare generally prohibits routine notices except for items and services that are experimental, subject to frequency limitations for coverage, or always denied for medical necessity. Durable medical equipment and supplies without a supplier number also fall under this exception. **Tips:** For an ABN issued for a specific item or service, rather than as a routine notice, report modifier GA, Waiver of liability statement issued as required by payer policy, individual case.
GV	**Attending physician not employed or paid under arrangement by the patient's hospice provider** **Definition:** A provider appends modifier GV to report that the patient's attending physician, is not an employee, or is not volunteering at the hospice provider of the patient. The attending physician may be a doctor specialized in a particular field, or a nurse practitioner. **Explanation:** A provider appends modifier GV when a provider performs a service related to the problem for which a patient was admitted into hospice. This provider is not a part of the hospice provider or their employee and provides services independently of the hospice. **Tips:** A patient, who opts for hospice coverage, waives his Medicare Part B payment for any treatment of terminal illness during the hospice period. However, there is an exception for the provider who attends the patient, referred to as attending physician in the modifier descriptor, who is not an employee of the hospice and is in no way attached to the hospice. The attending provider may also include a nurse practitioner, besides specific specialty providers.
GW	**Service not related to the hospice patient's terminal condition** **Definition:** A provider appends modifier GW to identify a service that the provider renders to a patient that is not related to the patient's terminal condition. **Explanation:** A provider appends modifier GW when the provider delivers a service, not related to the problem for which the patient was admitted into the hospice. This provider is not a part of the hospice or an employee of the hospice and provides the services independently. **Tips:** For Medicare payment, report modifier GW, if the patient's condition for hospice care is not related to the service.
GX	**Notice of liability issued, voluntary under payer policy** **Definition:** Append modifier GX to report issuance of a voluntary, or optional, advance beneficiary notice, or ABN, for any service not covered. **Explanation:** Modifier GX indicates the patient's receipt of a notice of liability, usually in the form of an advance beneficiary notice, or ABN, that is not required by payer policy, to let the patient know of his financial responsibility for items or services that Medicare never covers. The provider can bill the patient for items and services not subject to Medicare coverage whether or not the provider issues an ABN. **Tips:** Medicare reimburses modifier GX only if it is used secondary to modifier TS, Followup service, or modifier GY, Item or service statutorily excluded, does not meet the definition of any Medicare benefit, or for nonMedicare insurers, is not a contract benefit. If the patient has a secondary insurance that pays for the service, Medicare denies the reimbursement so that the provider can then submit the claim to the second payer. Medicare denies the reimbursement of modifier GX if the service is not covered by medical necessity.

Mod	Modifier Description, Definition, Explanation, and Tips
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** **Definition:** Append modifier GY to report services and supplies excluded by Medicare regulations or which are not a contract benefit for other payers. **Explanation:** Modifier GY denotes items or services not covered by Medicare under any circumstance, and the provider expects a denial. Medicare does not require the provider to present an advance beneficiary notice, or ABN, to bill the patient for these items or services. Some examples of items and services statutorily excluded by Medicare include acupuncture, cosmetic surgery, hearing aids, and most types of dental care. **Tips:** Modifier GY indicates that a particular service is not covered by Medicare. There is no need to submit an ABN to use modifier GY. You should not use modifier GY with add on codes.
GZ	**Item or service expected to be denied as not reasonable and necessary** **Definition:** Append modifier GZ when the provider expects a Medicare denial for an item or service as not a medical necessity but does not provide the patient with an advance beneficiary notice, or ABN. **Explanation:** Modifier GZ denotes an item or service for which the provider expects Medicare to deny reimbursement as not meeting the requirements of Medicare for medical necessity but for which the provider does not present the patient with an ABN. The provider may not bill the patient for the denied charges but can request a review. **Tips:** This is an informational modifier. Medicare processes claims with modifier GZ just like other claims. If the provider appends both modifier GZ and modifier GA, Waiver of liability statement issued as required by payer policy, individual case, on the same claim line, it is invalid and the claim is not reimbursable.
H9	**Court-ordered** **Definition:** Append modifier H9 to a code to indicate that a particular service was ordered by the court. **Explanation:** Modifier H9 denotes any service a patient undergoes by court order, such as a psychiatric evaluation, substance abuse treatment, foster care services, and others. **Tips:** For court ordered medical testimony, append modifier H9 to 99075, Medical testimony.
HA	**Child/adolescent program** **Definition:** Append modifier HA to designate the delivery of services through a program specifically designed for children and or adolescents. **Explanation:** Modifier HA denotes services a provider renders to a child or adolescent as part of a program designed specifically for children and or adolescents. Medicare does not cover this modifier, but Medicaid programs typically require modifier HA to indicate services provided to a child or adolescent. Specific use of the HA modifier may vary depending upon the program. **Tips:** See payer guidelines for specific codes that require or are eligible for the HA modifier.
HB	**Adult program, non-geriatric** **Definition:** Append modifier HB to designate the delivery of services to adult individuals, not including the elderly, as part of a care program for adults. **Explanation:** Modifier HB denotes services rendered to an adult participant a medical or psychiatric care program designed for adults. These include programs funded by Medicaid and other agencies. Use of the HB modifier may vary depending upon the program. **Tips:** See payer guidelines for specific codes that require or are eligible for the HB modifier.
HC	**Adult program, geriatric** **Definition:** Append modifier HC to designate services given to adult participants in a care program specifically designed for the elderly. **Explanation:** Modifier HC denotes services rendered to adults in a geriatric medical or psychiatric care program. These include programs funded by Medicaid and other agencies. Use of the HC modifier may vary depending upon the program. **Tips:** See payer guidelines for specific codes that require or are eligible for the HC modifier.
HD	**Pregnant/parenting women's program** **Definition:** A provider appends modifier HD to services designed for pregnant women or women with dependent children. **Explanation:** A provider appends this modifier to identify the services that he provides as a part of a program for women who are pregnant or women who have children. The services may include treatment for postpartum depression screening, or antepartum visits as well as alcohol and or drug detoxification, and behavioral health. **Tips:** Modifier HD is not payable by Medicare.

Mod	Modifier Description, Definition, Explanation, and Tips
HE	**Mental health program** **Definition:** Append modifier HE when the provider provides a particular service through a program specifically designed for the provision of mental health services. **Explanation:** Modifier HE denotes a service provided to a participant in a mental health services program, including those administered by state and local agencies. Use of the HE modifier may vary depending upon the program. **Tips:** See payer guidelines for specific codes that require or are eligible for the HE modifier.
HF	**Substance abuse program** **Definition:** Append modifier HF when the provider performs services for a participant in a substance abuse program. **Explanation:** Modifier HF denotes services provided to a participant in a substance abuse program. Specific use of the HF modifier varies depending upon the program and its sponsoring agency and payer. **Tips:** See payer guidelines for specific codes that require or are eligible for the HF modifier.
HG	**Opioid addiction treatment program** **Definition:** Append modifier HG when the provider performs services for a participant in an opioid addiction treatment program. **Explanation:** Modifier HG denotes services provided to a participant in an opioid addiction treatment program, including long term residential programs, outpatient programs, and methadone clinics. Specific use of the HG modifier varies depending upon the program and its sponsoring agency and payer. **Tips:** See payer guidelines for specific codes that require or are eligible for the HG modifier.
HH	**Integrated mental health/substance abuse program** **Definition:** Append modifier HH when the provider performs services for a participant in a combined mental health and substance abuse program. **Explanation:** Modifier HH denotes services provided to a participant in an integrated mental health and substance abuse program, including long term residential programs, outpatient programs, and others. Specific use of the HH modifier varies depending upon the program and its sponsoring agency and payer. **Tips:** See payer guidelines for specific codes that require or are eligible for the HH modifier.
HI	**Integrated mental health and intellectual disability/developmental disabilities program** **Definition:** Append modifier HI when the provider performs services for a participant in a program specifically for individuals with intellectual and or developmental disabilities. **Explanation:** Modifier HI denotes services provided to a participant in an intellectual disability and or developmental disabilities program. Specific use of the HI modifier varies depending upon the program and its sponsoring agency and payer. **Tips:** See payer guidelines for specific codes that require or are eligible for the HI modifier.
HJ	**Employee assistance program** **Definition:** Append modifier HJ when the provider performs services for a participant in an employee assistance program. **Explanation:** Modifier HJ denotes services provided to a participant in an employee assistance program, or EAP. Specific use of the HJ modifier varies depending upon the EAP and its sponsoring agency and payer, which may be a state Medicaid program. **Tips:** See payer guidelines for specific codes that require or are eligible for the HJ modifier.
HK	**Specialized mental health programs for high-risk populations** **Definition:** Append modifier HK when the provider performs services for a participant in a mental health program designed for groups of people who are at greater risk for mental illness. **Explanation:** Modifier HK denotes services provided to individuals who participate in a specialized mental health program for high risk populations, such as the elderly, low income families, substance abusers, and people with a history of mental illness. Specific use of the HK modifier varies depending upon the program and its sponsoring agency and payer. **Tips:** See payer guidelines for specific codes that require the HK modifier.

Mod	Modifier Description, Definition, Explanation, and Tips
HL	**Intern** **Definition:** Append modifier HL to the code when an intern performs a behavioral health service. **Explanation:** Append this modifier to a behavioral health service code to show that the provider is an intern. The condition of the patient may require an intern to render the service. **Tips:** HCPCS modifiers HL through HP identify the level of education of a provider who performs psychological or psychiatric services. These codes are not covered by Medicare, but some carriers may base payment for services on the provider's education level.
HM	**Less than bachelor degree level** **Definition:** Append modifier HM to the code when a provider with less than a bachelor's degree level of education performs a behavioral health service. **Explanation:** Append this modifier to a behavioral health service code to show that the provider holds less than a bachelor's degree level of education. The condition of the patient may require a provider with less than a bachelor's degree level of education to render the service. **Tips:** HCPCS modifiers HL through HP identify the level of education of a provider who performs psychological or psychiatric services. These codes are not covered by Medicare, but some carriers may base payment for services on the provider's education level.
HN	**Bachelor's degree level** **Definition:** Append modifier HN to the code when a provider who holds a bachelor's degree performs a behavioral health service. **Explanation:** Append this modifier to a behavioral health service code to show that the provider holds a bachelor's degree. The condition of the patient may require a provider with a bachelor's degree level of education to render the service. **Tips:** HCPCS modifiers HL through HP identify the level of education of a provider who performs psychological or psychiatric services. These codes are not covered by Medicare, but some carriers may base payment for services on the provider's education level.
HO	**Master's degree level** **Definition:** Append modifier HO to the bill for any behavioral health service by a provider with a master's degree. **Explanation:** Append this modifier to a behavioral health service code to show that the provider holds a master's degree. The condition of the patient may require the provider of master's degree level to render the service. **Tips:** HCPCS modifiers HL through HP identify the level of education of the provider who performs psychological or psychiatric services. These codes are not covered by Medicare, but some carriers do base payment for services on the provider's education level. If the provider is an intern, use modifier HL, Intern. If the provider holds less than a bachelor's degree, append modifier HM, Less than bachelor degree level. If the provider holds a bachelor's degree, append modifier HN, Bachelors degree level. If the provider is of a doctoral level, use modifier HP, Doctoral level. You should append modifier HO with the code H2011, Crisis intervention service, per 15 minutes. This code includes crisis intervention in an emergency setting for patients and the families of patients who exhibit extreme mental duress with disturbed thoughts, mood, or behavior.
HP	**Doctoral level** **Definition:** Append modifier HP to a bill for any behavioral health service that a provider with a doctoral degree, e.g., PhD, provides to the patient. **Explanation:** Append this modifier to a behavioral health service code to show that the provider holds a doctoral level degree, i.e., PhD. The medical documentation should justify the treatment by a provider who holds a doctoral degree. The condition of the patient may require the provider of doctoral level to render the service. The doctoral level provider offers services to improve the mental health of the patient. **Tips:** HCPCS modifiers HL through HP identify the level of education of the provider who performs psychological or psychiatric services. These codes are not covered by Medicare, but some carriers do base payment for services on the provider's education level. When using the modifier HP, you should remember that the provider, who renders the service for behavioral health, must be of doctoral level. If the provider is an intern, use modifier HL, Intern. If the provider holds less than a bachelor's degree, append modifier HM, Less than bachelor degree level. If the provider holds a bachelor's degree, append modifier HN, Bachelors degree level. If the provider is of a masters degree level, use modifier HO, Masters degree level.

Mod	Modifier Description, Definition, Explanation, and Tips
HQ	**Group setting** **Definition:** Append modifier HQ to a service when the provider renders service for behavioral care to patients in a group setting. **Explanation:** Append this modifier to a behavioral health service code to show that the provider rendered the behavioral health services in a group setting. The medical documentation should justify the treatment of the patients in a group setting by a provider who is not a physician. The patient's condition may necessitate the service for behavioral healthcare. The provider offers this service to improve the mental and behavioral health of the patient in a group setting. **Tips:** You should append modifier HQ with codes that include services such as comprehensive community support, psychosocial rehabilitation, family training, developmental therapy, or group supported living.
HR	**Family/couple with client present** **Definition:** Append modifier HR to a service in which the provider renders therapy to the family or couples in the presence of a client. **Explanation:** Append this modifier to a behavioral health service code to show that the provider offers therapy to a family or couple in the presence of a client. The medical documentation must justify the mental health therapy for the family or couple with the client present. The client refers to the patient who requires the therapy. The provider offers mental health therapy to the patient in the presence of his family. The provider renders this service to improve the mental and behavioral health of the patient. **Tips:** If the patient is not present at the therapy session, use modifier HS. You should append modifier HR to the services that include services such as mental health therapy, psychiatry, activity therapy, or other health services.
HS	**Family/couple without client present** **Definition:** Append modifier HR to a service in which the provider renders therapy to the family or couple in the absence of a client. **Explanation:** Append this modifier to a behavioral health service code to show that the provider met with the family or partner of a client without the client present. The medical documentation must justify the mental health therapy of the families or couple in the absence of a client. The client refers to the patient who needs the therapy. The provider renders this service to improve the mental and behavioral health of the patient. **Tips:** If the patient is present for the therapy session, use the modifier HR, Family or couple with client present. You should append modifier HS to the services that include services such as mental health therapy, psychiatry, activity therapy, or other health services.
HT	**Multi-disciplinary team** **Definition:** Append modifier HT to a service when a multidisciplinary team renders service for behavioral care to the patient. **Explanation:** Append this modifier to a behavioral health service code to show that a team of providers with different areas of expertise treated the patient. The medical documentation should justify the treatment of the patients by a multidisciplinary team of providers, who are not physicians. The patient's condition may necessitate the service for behavioral healthcare. The multidisciplinary team refers to the group of individuals from different fields and come together for assessment and consultations of patients. The providers offer this service to improve the mental and behavioral health of the patient in a multidisciplinary team. **Tips:** You should append modifier HT with codes that include services such as comprehensive community support, psychosocial rehabilitation, family training, developmental therapy, or group supported living.

Mod	Modifier Description, Definition, Explanation, and Tips
HU	**Funded by child welfare agency** **Definition:** Append modifier HU to the service when the provider receives funds from a child welfare agency for therapy provided to a patient. **Explanation:** Append this modifier to a behavioral health service code to show that the provider receives funds from a child welfare agency for therapy that he provides patients. The medical documentation must validate that the child welfare agency funds the treatment service for the patient. It is the agency that arranges the financing for the therapy that the patient undergoes. The provider utilizes the resources from a child welfare agency and offers mental and behavioral healthcare to the patient. **Tips:** HCPCS modifiers HU through HZ identify government and other agency funding for mental health services. When using the modifier HU, you should remember that the child welfare agency funds the service. If the state addictions agency funds the service code, use modifier HV, Funded state addictions agency. If the provider receives funds from state mental health agency, use modifier HW, Funded by state mental health agency. If the county or local agency finances the service code, append modifier HX, Funded by county or local agency. If the juvenile justice agency offers money for the service code, append modifier HY, Funded by juvenile justice agency. If the criminal justice agency funds the service code, use modifier HZ, Funded by criminal justice agency.
HV	**Funded state addictions agency** **Definition:** Append modifier HV to the service when the provider receives funds from a state addictions agency, to offer therapy to the patients. **Explanation:** Append this modifier to a behavioral health service code to show that the provider receives funds from a state addictions agency for therapy that he offers patients. The medical documentation must validate that the state addictions agency funds the treatment service for the patient. It is the agency that arranges the financing for the therapy that the patient undergoes. The provider utilizes the resources from a state addictions agency and offers mental and behavioral healthcare to the patient. **Tips:** HCPCS modifiers HU through HZ identify government and other agency funding for mental health services. When using the modifier HV, you should remember that the state addictions agency funds the service. If the child welfare agency funds the service code, use modifier HU, Funded by child welfare agency. If the provider receives funds from state mental health agency, use modifier HW, Funded by state mental health agency. If the county or local agency finances the service code, append modifier HX, Funded by county or local agency. If the juvenile justice agency offers money for the service code, append modifier HY, Funded by juvenile justice agency. If the criminal justice agency funds the service code, use modifier HZ, Funded by criminal justice agency.
HW	**Funded by state mental health agency** **Definition:** Append modifier HW to the service when the provider receives funds from a state mental health agency to provide therapy for a patient. **Explanation:** Append this modifier to a behavioral health service code to show that the provider receives funds from a state mental health agency for therapy that he provides patients. The medical documentation must validate that the state mental health agency funds the treatment service for the patient. It is the agency that arranges the financing for the therapy that the patient undergoes. The provider utilizes the resources from state mental health agency and offers mental and behavioral healthcare to the patient. **Tips:** HCPCS modifiers HU through HZ identify government and other agency funding for mental health services. When using the modifier HW, you should remember that the state mental health agency funds the service. If the child welfare agency funds the service code, use modifier HU, Funded by child welfare agency. If the state addictions agency funds the service code, use modifier HV, Funded state addictions agency. If the county or local agency finances the service code, append modifier HX, Funded by county or local agency. If the juvenile justice agency offers money for the service code, append modifier HY, Funded by juvenile justice agency. If the criminal justice agency funds the service code, use modifier HZ, Funded by criminal justice agency.

Mod	Modifier Description, Definition, Explanation, and Tips
HX	**Funded by county/local agency** **Definition:** Append modifier HX to the service when the provider receives funds from a county or local agency to provide therapy to a patient. **Explanation:** Append this modifier to a behavioral health service code to show that the provider receives funds from a county or local agency for therapy that he provides patients. The medical documentation must validate that the county or local agency funds the treatment service for the patient. It is the agency that arranges the financing for the therapy that the patient undergoes. The provider utilizes the resources from county or local agency and offers mental and behavioral healthcare to the patient. **Tips:** HCPCS modifiers HU through HZ identify government and other agency funding for mental health services. When using the modifier HX, you should remember that the county or local agency funds the service. If the child welfare agency funds the service code, use modifier HU, Funded by child welfare agency. If the state addictions agency funds the service code, use modifier HV, Funded state addictions agency. If the provider receives funds from state mental health agency, use modifier HW, Funded by state mental health agency. If the juvenile justice agency offers money for the service code, append modifier HY, Funded by juvenile justice agency. If the criminal justice agency funds the service code, use modifier HZ, Funded by criminal justice agency.
HY	**Funded by juvenile justice agency** **Definition:** Append modifier HY to the service when the provider receives funds from a juvenile justice agency to provide therapy to a patient. **Explanation:** Append this modifier to a behavioral health service code to show that the provider receives funds from a juvenile justice agency for therapy that he provides patients. The medical documentation must validate that the juvenile justice agency funds the treatment service for the patient. It is the agency that arranges the financing for the therapy that the patient undergoes. The provider utilizes the resources from juvenile justice agency and offers mental and behavioral healthcare to the patient. **Tips:** HCPCS modifiers HU through HZ identify government and other agency funding for mental health services. When using the modifier HY, you should remember that the juvenile justice agency funds the service. If the child welfare agency funds the service code, use modifier HU, Funded by child welfare agency. If the state addictions agency funds the service code, use modifier HV, Funded state addictions agency. If the provider receives funds from state mental health agency, use modifier HW, Funded by state mental health agency. If the county or local agency finances the service code, append modifier HX, Funded by county or local agency. If the criminal justice agency funds the service code, use modifier HZ, Funded by criminal justice agency.
HZ	**Funded by criminal justice agency** **Definition:** Append modifier HZ to the service when the provider receives funds from the criminal justice agency to provide therapy to a patient. **Explanation:** Append this modifier to a behavioral health service code to show that the provider receives funds from a criminal justice agency for therapy that he provides patients. The medical documentation must validate that the criminal justice agency funds the treatment service for the patient. It is the agency that arranges the financing for the therapy that the patient undergoes. The provider utilizes the resources from criminal justice agency and offers mental and behavioral healthcare to the patient. **Tips:** HCPCS modifiers HU through HZ identify government and other agency funding for mental health services. When using the modifier HZ, you should remember that the criminal justice agency funds the service. If the child welfare agency funds the service code, use modifier HU, Funded by child welfare agency. If the state addictions agency funds the service code, use modifier HV, Funded state addictions agency. If the provider receives funds from state mental health agency, use modifier HW, Funded by state mental health agency. If the county or local agency finances the service code, append modifier HX, Funded by county or local agency. If the juvenile justice agency offers money for the service code, append modifier HY, Funded by juvenile justice agency.

Mod	Modifier Description, Definition, Explanation, and Tips
J1	**Competitive acquisition program no-pay submission for a prescription number** **Definition:** Providers enrolled in the Competitive Acquisition Program, or CAP, for drugs and biologicals append modifier J1 to the code for a drug, along with number of prescriptions. **Explanation:** The medical documentation should justify the number of prescriptions of a drug that the provider administers to the patient. Modifier J1 indicates that the drug is a no pay item and the provider obtains it through CAP. This reflects that the patient does not pay for the drug. Competitive Acquisition Program refers to a program in which the provider buys and bills for certain drugs and biologicals obtained from approved CAP vendors and administer them to the beneficiary patient. Although this modifier is still active, the CAP program was suspended at the end of 2008. **Tips:** When using modifier J1, the provider who prescribes the drug must be enrolled in the Competitive Acquisition Program. You can combine the modifier J1 with modifier J2, Competitive Acquisition Program, restocking of emergency drugs after emergency administration, on the same line. The CAP is an alternative to the average sales price, or ASP, methodology for acquiring certain Part B drugs administered in physicians' offices. Participating CAP providers must obtain all CAP drugs from an Approved CAP Vendor. Drugs that are not available through the CAP can be purchased through the ASP methodology. The CAP program was suspended on December 31, 2008.
J2	**Competitive acquisition program, restocking of emergency drugs after emergency administration** **Definition:** Providers enrolled in the Competitive Acquisition Program, or CAP, for drugs and biologicals append modifier J2 when the provider restocks drugs administered in an emergency situation. **Explanation:** The medical documentation should justify that the patient had an immediate requirement for the drug, which the provider administers to the patient. Modifier J2 indicates that the provider needs to restock the emergency drugs for when the vendor cannot deliver the drug on time or when an urgent need for the drug occurs. Competitive Acquisition Program refers to a program in which the provider buys and bills for certain drugs and biologicals obtained from approved CAP vendors and administer them to the beneficiary patient. Although this modifier is still active, the CAP program was suspended at the end of 2008. **Tips:** When using modifier J2, the provider who prescribes the drug must be enrolled in the competitive acquisition program. You can combine the modifier J2 with modifier J1, Competitive acquisition program no pay submission for a prescription number, on the same line. The CAP is an alternative to the average sales price, or ASP, methodology for acquiring certain Part B drugs administered in physicians' offices. Participating CAP providers must obtain all CAP drugs from an Approved CAP Vendor. Drugs that are not available through the CAP can be purchased through the ASP methodology. The CAP program was suspended on December 31, 2008.
J3	**Competitive acquisition program (CAP), drug not available through CAP as written, reimbursed under average sales price methodology** **Definition:** Append modifier J3 when the provider is enrolled in the Competitive Acquisition Program, or CAP, for drugs and biologicals, but the drug is not available from a CAP vendor; reimbursement will be made using the average sales price, or ASP, methodology. **Explanation:** The medical documentation should justify that the drug is not available from the approved CAP vendor, and the CAP enrolled provider orders and purchases the drug or biological from a source other than the approved CAP vendor. Competitive Acquisition Program refers to a program in which the provider buys and bills for certain drugs and biologicals obtained from approved CAP vendors and administer them to the beneficiary patient. Although this modifier is still active, the CAP program was suspended at the end of 2008. **Tips:** When using modifier J3, the provider who prescribes the drug must be enrolled in the Competitive Acquisition Program. You cannot combine modifier J3 with modifier J1, Competitive Acquisition Program no pay submission for a prescription number, or modifier J2, Competitive Acquisition Program, restocking of emergency drugs after emergency administration, on the same line. If the provider orders the drug from an alternate method, i.e., other than the approved CAP vendor, and the patient is a primary Medicare beneficiary, use modifier M2, Medicare secondary payer, MSP. The CAP is an alternative to the average sales price, or ASP, methodology for acquiring certain Part B drugs administered in physicians' offices. Participating CAP physicians must obtain all CAP drugs from an Approved CAP Vendor. Drugs that are not available through the CAP can be purchased through the ASP methodology. The CAP program was suspended on December 31, 2008.

Mod	Modifier Description, Definition, Explanation, and Tips
J4	**DMEPOS item subject to DMEPOS competitive bidding program that is furnished by a hospital upon discharge** **Definition:** Append modifier J4 when the provider supplies durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS, to a Medicare patient upon discharge from the hospital. Report this modifier only if the patient's permanent residence is in a competitive bidding area, or CBA. **Explanation:** Modifier J4 indicates that a Medicare patient received DMEPOS, such as a walker or related accessories, upon discharge from the hospital. Patients may use the equipment in their homes, since part A payment for inpatient hospital services includes the payment for these items. The competitive bidding program covers the changes for certain durable medical equipment, prosthetics, orthotics, and supplies for payment by Medicare to the suppliers. It converts outdated prices to lower and more accurate prices. **Tips:** When using modifier J4, the provider who offers the DMEPOS to the patient on discharge from the hospital cannot be a contract supplier. Providers most commonly append this modifier to HCPCS codes that refer to the use of durable medical equipment. Use the modifier J4 if the patient, who receives the DMEPOS, permanently resides in a competitive bidding area, even if the provider who supplies the equipment is outside the competitive bidding area.
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** **Definition:** Append modifier J5 when the provider supplies an off-the-shelf orthotic subject to the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Report this modifier when the orthotic is furnished as part of a physical therapist or occupational therapist professional service. **Explanation:** Modifier J5 indicates that a Medicare patient received an off-the-shelf orthotic as a part of a physical therapist or occupational therapist professional service. Off-the-shelf orthotics are prefabricated supplies that require minimal self-adjustment to fit the patient and ensure that the treatment goals are met. Examples are certain leg, arm, back, and neck braces. The orthotic must be subject to the DMEPOS Competitive Bidding Program for the modifier to apply. Under the program, certain items are subject to competitive bidding, and Medicare awards contracts to suppliers who offer the best price and meet quality and financial standards. **Tips:** Medicare identifies the specific off-the-shelf (OTS) orthotic codes included in a competitive bidding program.
JA	**Administered intravenously** **Definition:** CMS encourages providers to append modifier JA to all intravenous injection codes, but especially when the provider administers erythropoiesis stimulating agents, or ESAs, intravenously to patients with end stage renal disease, or ESRD. Modifier JA is informational and does not affect payment. **Explanation:** Use modifier JA to report the administration of drugs covered by HCPCS intravenous injection codes. CMS encourages providers who intravenously administer erythropoiesis stimulating agents to patients with end stage renal disease to append this modifier for tracking purposes. Any claim for erythropoiesis stimulating agents or ESA administration, ESRD facilities must include the hemoglobin and or hematocrit values, the route of administration using the JA or JB modifier code, and the Kt/V, calculated using a specified formula, to indicate the adequacy of dialysis. When the kidneys fail to function, the patient undergoes dialysis to remove waste products from the blood. The provider collects a blood sample to measure the level of hemoglobin and hematocrit before the dialysis treatment. If the patient is found to be anemic, the provider administers intravenous or subcutaneous ESAs. ESAs stimulate red blood cell production in patients with anemia that results from conditions such as chronic kidney failure, chemotherapy, and other treatments. It includes agents like epoetin alfa and darbepoetin alfa. **Tips:** If the provider uses subcutaneous route to administer the ESAs, append modifier JB, Administered subcutaneously, with the code. Failure to include the JA or JB modifier for ESA route of administration when reporting Q4081, Injection, epoetin alfa, 100 units, for ESRD on dialysis, or J0882, Injection, darbepoetin alfa, 1 mcg, for ESRD on dialysis, on a 72X type of bill will result in that bill being returned to the provider.

Mod	Modifier Description, Definition, Explanation, and Tips
JB	**Administered subcutaneously** **Definition:** CMS encourages providers to append modifier JB to all subcutaneous injection codes, but especially when the provider administers erythropoiesis stimulating agents, or ESAs, intravenously to patients with end stage renal disease, or ESRD. Modifier JB is informational and does not affect payment. **Explanation:** Use modifier JB to report the administration of drugs covered by HCPCS subcutaneous injection codes. CMS encourages providers who subcutaneously administer erythropoiesis stimulating agents to patients with end stage renal disease to append this modifier for tracking purposes. Any claim for erythropoiesis stimulating agents or ESA administration, ESRD facilities must include the hemoglobin and or hematocrit values, the route of administration using the JA or JB modifier code, and the Kt/V, calculated using a specified formula, to indicate the adequacy of dialysis. When the kidneys fail to function, the patient undergoes dialysis to remove waste products from the blood. The provider collects a blood sample to measure the level of hemoglobin and hematocrit before the dialysis treatment. If the patient is found to be anemic, the provider administers intravenous or subcutaneous ESAs. ESAs stimulate red blood cell production in patients with anemia that results from conditions such as chronic kidney failure, chemotherapy, and other treatments. It includes agents like epoetin alfa and darbepoetin alfa. **Tips:** If the provider uses intravenous route to administer the ESAs, append modifier JA, Administered intravenously, with the code. Failure to include the JA or JB modifier for ESA route of administration when reporting Q4081, Injection, epoetin alfa, 100 units, for ESRD on dialysis, or J0882, Injection, darbepoetin alfa, 1 microgram, for ESRD on dialysis, on a 72X type of bill will result in that bill being returned to the provider.
JC	**Skin substitute used as a graft** **Definition:** Append modifier JC to codes when the provider uses a skin substitute as a graft to replace debrided tissue in a wound. **Explanation:** Modifier JC indicates that the provider replaced debrided tissue in a wound with a skin substitute. The medical documentation should justify the use of a skin substitute as a graft to replace the debrided tissue in a wound. The provider implants or inserts the skin substitute into the wound to aid healing, and replace the devitalized or nonviable tissue. **Tips:** Providers most commonly append this modifier to HCPCS codes for skin substitutes when used to treat wounds, infections, or ulcers. The substitute typically replaces the dermal and epidermal layers of the skin. If the provider uses the skin substitute as a covering, and not as a graft, append modifier JD, Skin substitute not used as a graft. Submit HCPCS modifier JC or HCPCS modifier JD with HCPCS codes Q4100, Skin substitute, not otherwise specified as well as Q4101 through Q4121 and Q4136 to Q4137, codes that specify brands or types of skin substitutes.
JD	**Skin substitute not used as a graft** **Definition:** Append modifier JD when the provider uses a skin substitute to cover wound due to inadequate skin available for coverage. **Explanation:** Modifier JD indicates that the provider used a skin substitute because of inadequate skin available to cover the wound. The medical documentation should justify the use of skin substitute to cover the wound. The provider uses the skin substitute as a dressing to cover the wound, to help protect it from contamination, and to replace defective tissue. The provider repairs or replaces the defective tissue with an artificial skin substitute, which aids in the healing process. **Tips:** When using the modifier JD, the skin substitute fits over the wound site. Providers most commonly append this modifier to HCPCS codes for skin substitutes when used to treat wounds, infections, or ulcers. The substitute typically replaces the dermal and epidermal layers of the skin. If the provider uses the skin substitute as a graft, and not as a covering, append modifier JC, Skin substitute used as a graft. Submit HCPCS modifier JC or HCPCS modifier JD with HCPCS codes Q4100, Skin substitute, not otherwise specified as well as Q4101 through Q4121 and Q4136 to Q4137, codes that specify brands or types of skin substitutes.

Mod	Modifier Description, Definition, Explanation, and Tips
JE	**Administered via dialysate** **Definition:** Append modifier JE when the provider administers drugs and biologicals mixed in the dialysate solution, through any route of dialysate administration, to patients with end stage renal disease, or ESRD. **Explanation:** Modifier JE indicates that the provider administered drugs or biologicals to a patient with end stage renal disease, or ESRD, via the dialysate. The provider compounds the dialysate with injectable drugs and biologicals to administer to the patient. When the kidneys fail to function properly, patients undergo dialysis to remove waste products from the blood. The process of dialysis uses a fluid, called dialysate, which contains soluble substances and helps to remove toxic products from the blood. **Tips:** If the provider administers drugs or biologicals to a patient without ESRD, append modifier AY, Item or service furnished to an ESRD patient that is not for the treatment of ESRD.
JK	**One month supply or less of drug or biological** **Definition:** Append modifier JK to a code when you report a one-month supply or less of a drug or biological. **Explanation:** Append this modifier to a code to indicate to the payer that you are reporting a one-month supply or less of a drug or biological. Check individual payer and contractor reporting rules regarding proper use of this modifier, as rules may vary. **Tips:** The original intent of this modifier was to identify the supply of insulin subject to a coinsurance cap.
JL	**Three month supply of drug or biological** **Definition:** Append modifier JL to a code when you report a three-month supply of a drug or biological. **Explanation:** Append this modifier to a code to indicate to the payer that you are reporting a three-month supply of a drug or biological. Check individual payer and contractor reporting rules regarding proper use of this modifier, as rules may vary. **Tips:** The original intent of this modifier was to identify the supply of insulin subject to a coinsurance cap.
JW	**Drug amount discarded/not administered to any patient** **Definition:** Append modifier JW when billing for a drug or biological for which the provider discards the remainder of a single dose vial after administering a portion of the drug to the patient. **Explanation:** Append this modifier to the drugs and biologicals codes to show that the provider administers the necessary or prescribed amount of a drug supplied in a single dose vial and discards the remaining amount of the drug. The medical documentation must include the amount of the drug that the provider discards, along with the reason for the same. **Tips:** Some drugs are billed by dose, so if the dose administered is less than the amount of a drug supplied in a single use vial, append modifier JW to bill the amount of the drug discarded. You must bill the amount of drug used and the amount discarded separately. Other drugs are billed by units, as specified in the code's official descriptor. For these drugs, if the administered dose is less than the amount specified in the OD, the provider bills for the unit specified in the OD. Do not append the JW modifier in this case because the provider is paid by the unit specified in the OD and not the amount actually administered.
JZ	**Zero drug amount discarded/not administered to any patient** **Definition:** Append modifier JZ to the code for a drug or biological in a single-use vial or single-use package when there is no discarded amount after administering the agent to the patient. **Explanation:** Append this modifier to the supply code for a drug or biological to show that there is no discarded amount to report after administration to the patient. This code applies when the agent is in a single-use vial or single-use package. **Tips:** See modifier JW when the provider discards the remainder of a single-use vial or single-use package after administering a portion to the patient.

Mod	Modifier Description, Definition, Explanation, and Tips
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** **Definition:** Append modifier K0 to cover the use of lower limb prosthetic device that does not contribute to the patient's ability to move safely with or without any support, nor does the prosthetic device enhance the patient's quality of life or mobility. **Explanation:** Append this modifier to a claim for a lower limb prosthesis to indicate a functional state of zero for the patient for whom the provider supplies the prosthesis. The medical documentation must illustrate that the functional level of the patient, even with the lower limb prosthesis, is zero, i.e., the patient cannot move about independently, or even with assistance, and the prosthesis device does not improve the quality of life of the patient. CMS requires that documentation for a claim for lower limb prosthesis should accurately reflect the beneficiary's medical conditions that necessitate the use of the specific lower limb prosthesis as well as medical conditions that would impact the beneficiary's ability to effectively utilize the device in achieving a defined functional state. **Tips:** HCPCS modifiers K0 through K4 apply to the supply of lower limb prostheses and identify the functional level that a patient motivated to ambulate reaches or maintains within a reasonable time period. Modifier K1 indicates that the patient has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence, typical of the limited and unlimited household ambulator. Modifier K2 indicates that the patient 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. Modifier K3 indicates that the patient has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion. Modifier K4 indicates that the patient has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete.
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** **Definition:** Append modifier K1 to cover the use of lower limb prosthetic device that contributes to the patient's ability to move safely on level surface at a fixed pace, typical of a patient who goes about his normal activities within his home. **Explanation:** Append this modifier to a claim for lower limb prosthesis to indicate a functional state of one for the patient for whom the provider supplies the prosthesis. The medical documentation must illustrate that the functional level of the patient with the lower limb prosthesis is one, i.e., the patient is able to move about independently on level surfaces at a fixed rhythm with the help of the prosthetic device. CMS requires that documentation for a claim for lower limb prosthesis should accurately reflect the beneficiary's medical conditions that necessitate the use of the specific lower limb prosthesis as well as medical conditions that would impact the beneficiary's ability to effectively utilize the device in achieving a defined functional state. **Tips:** HCPCS modifiers K0 through K4 apply to the supply of lower limb prosthesis and identify the functional level that a patient motivated to ambulate reaches or maintains within a reasonable time period. Modifier K0 indicates that the patient has a functional level of zero, i.e., the patient cannot move about independently, or even with assistance, and the prosthetic device does not improve the quality of life of the patient. Modifier K2 indicates that the patient 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. Modifier K3 indicates that the patient has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion. Modifier K4 indicates that the patient has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete.

Mod	Modifier Description, Definition, Explanation, and Tips
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** **Definition:** Append modifier K2 to a code for a lower limb prosthetic device that contributes to the patient's ability to move safely over low level barriers, such as stairs or other uneven surfaces. **Explanation:** Append this modifier to a claim for lower limb prosthesis to indicate a functional state of two for a patient for whom the provider supplies lower limb prosthesis. The medical documentation must illustrate that the functional level of the patient with the lower limb prosthesis is two, i.e., the patient can move about independently over low level surfaces, such as stairs, and even control his motion, with the help of the prosthetic device. CMS requires that support of a claim for lower limb prosthesis should accurately reflect the beneficiary's medical conditions that necessitate the use of the specifically ordered lower limb prosthesis as well as beneficiary's medical conditions that would impact the beneficiary's ability to effectively utilize the specifically ordered lower limb prosthesis in achieving a defined functional state. **Tips:** HCPCS modifiers K0 through K4 apply to the supply of lower limb prosthesis and identify the functional level that a patient motivated to ambulate reaches or maintains within a reasonable time period. Modifier K0 indicates that the patient does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance their quality of life or mobility. Modifier K1 indicates that the patient has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence, typical of the limited and unlimited household ambulator. Modifier K3 indicates that the patient has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion. Modifier K4 indicates that the patient has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete.
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** **Definition:** Append modifier K3 to the code for a lower limb prosthetic device that contributes to the patient's ability to move safely over most barriers with a variable pace and to perform certain activities that are beyond the use of the device. **Explanation:** Append this modifier to a claim for lower limb prosthesis to identify a functional state of three for a patient for whom the provider supplies lower limb prosthesis. The medical documentation must illustrate that the functional level of the patient with the lower limb prosthesis is three, i.e., the patient can move about independently over most barriers with variable rhythm. The patient employs the prosthetic device to perform activities, such as exercise, vocational activities, and therapeutic activities, as well as ambulation. CMS requires that documentation for a claim for lower limb prosthesis should accurately reflect the beneficiary's medical conditions that necessitate the use of the specific lower limb prosthesis as well as medical conditions that would impact the beneficiary's ability to effectively utilize the device in achieving a defined functional state. **Tips:** HCPCS modifiers K0 through K4 apply to the supply of lower limb prosthesis and identify the functional level that a patient motivated to ambulate reaches or maintains within a reasonable time period. Modifier K0 indicates that the patient does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance their quality of life or mobility. Modifier K1 indicates that the patient has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence, typical of the limited and unlimited household ambulator. Modifier K2 indicates that the patient 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. Modifier K4 indicates that the patient has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete.

Mod	Modifier Description, Definition, Explanation, and Tips
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** **Definition:** Append modifier K4 to the code for a lower limb prosthetic device that contributes to the patient's ability to move about safely and engage in high energy activities typical of the prosthetic demands of a child, active adult, or athlete. **Explanation:** Append this modifier to a claim for lower limb prosthesis to identify a functional state of four for a patient for whom the provider supplies the lower limb prosthesis. The medical documentation must illustrate that the functional level of the lower limb prosthesis is four, i.e., the patient can move about independently and engage in high energy activities, such as those of a healthy child, active adult, or athlete. CMS requires that documentation for a claim for lower limb prosthesis should accurately reflect the beneficiary's medical conditions that necessitate the use of the specific lower limb prosthesis as well as medical conditions that would impact the beneficiary's ability to effectively utilize the device in achieving a defined functional state. **Tips:** HCPCS modifiers K0 through K4 apply to the supply of lower limb prosthesis and identify the functional level that a patient motivated to ambulate reaches or maintains within a reasonable time period. Modifier K0 indicates that the patient does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance their quality of life or mobility. Modifier K1 indicates that the patient has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence, typical of the limited and unlimited household ambulator. Modifier K2 indicates that the patient 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. Modifier K3 indicates that the patient has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
KA	**Add on option/accessory for wheelchair** **Definition:** Append this modifier to wheelchair codes for the supply of accessories and options. **Explanation:** Append modifier KA to show that the provider supplies accessories and options for a wheelchair to a patient. Numerous HCPCS codes exist for wheelchair options and accessories, for purchase or rental. **Tips:** Append this modifier to HCPCS codes E0955, Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each; E0985 through E2378 for wheelchair accessories, with the exception of codes for power wheelchair interfaces for which you would append modifier KC. You may also append modifier KA to K0015, Detachable nonadjustable height armrest and K0070, Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each.
KB	**Beneficiary requested upgrade for ABN, more than 4 modifiers identified on claim** **Definition:** Append modifier KB to a claim for durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS, when an advanced beneficiary notice, or ABN, applies when there are more than four modifiers on a claim line. **Explanation:** Append this modifier to a claim for DMEPOS items that require an advance beneficiary notice or ABN, for line items that need more than four modifiers on the claim. An Advance Beneficiary Notice refers to a standardized notice that the provider or supplier issues to a Medicare beneficiary before providing certain outpatient or hospice, home health agencies, and religious nonmedical healthcare institutions items or services. An ABN must be issued when the provider believes Medicare may not pay for an item or service that Medicare usually covers and that Medicare may not consider medically reasonable and necessary for the patient in this particular instance. Additional guidelines apply to hospices, home health agencies, and durable medical equipment suppliers. The patient must have original Medicare rather than Medicare Advantage plans. The KB modifier only applies to claims for DMEPOS where the supplier obtained an ABN. If providers or suppliers do not issue a valid ABN to the beneficiary when Medicare requires it, they cannot bill the beneficiary for the service and may be financially liable if Medicare doesn't pay. **Tips:** When reporting the modifier KB, you should remember that an ABN applies when more than four modifiers are present on the claim line. In cases when the supplier does not issue an ABN, and the provider reports more than four modifiers, append modifier 99, Multiple modifiers.

Mod	Modifier Description, Definition, Explanation, and Tips
KC	**Replacement of special power wheelchair interface** **Definition:** Append modifier KC to a claim for the replacement of the interface for a power mobility device, i.e., the wheelchair, in a multiple competitive bidding product category. **Explanation:** Append this modifier when the interface is used with a competitively bid complex rehabilitative power mobility device base code. Interface refers to the way the patient causes a power wheelchair to move, such as a hand or chin control interface, sip and puff tube, or compact remote joystick. As a patient's physical condition deteriorates, he may require a change in the control interface. CMS added the KC modifier to cover the full cost of a special power wheelchair interface replacement when a change in the patient's medical condition makes the existing interface difficult or impossible for the patient to use or in cases where the existing interface is irreparably damaged or has exceeded its reasonable useful lifetime, when the interface is supplied through competitive bidding complex categories. **Tips:** When using the modifier KC, you should remember that the code identifies only competitive bidding complex categories. If the code covers both competitive and noncompetitive bidding categories, append modifier KE, Bid under round one of the DMEPOS competitive bidding program for use with noncompetitive bid base equipment. Append modifier KC to HCPCS codes for various types of power wheelchair interfaces when the accessory supplied with a competitively bid complex rehabilitative PMD base code. These include E2321 to E2330, Power wheelchair accessories, etc.; E2312, Power wheelchair accessory, hand or chin control interface, mini proportional remote joystick, proportional, including fixed mounting hardware; E2351, Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface; E2373, Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware; E2374, Power wheelchair accessory, hand or chin control interface, standard remote joystick, not including controller, proportional, including all related electronics and fixed mounting hardware, replacement only; and K0835 thru K0864, Power wheelchair, groups two and three.
KD	**Drug or biological infused through DME** **Definition:** Append modifier KD to a code for a drug or biological, which the provider infuses through a durable medical equipment, or DME, such as an implanted infusion pump. **Explanation:** Append this modifier for drugs and biologicals to show that the provider instills the drug through an implanted infusion pump categorized as a DME. Providers surgically implant infusion pumps in patients who need long term medication. The pump can deliver the drug in a measured dose at a continuous rate or intermittently. Medicare covers the intravenous, intraarterial, subcutaneous, intrathecal, or epidural administration of certain drugs via an infusion pump, such as those used for heart failure and pulmonary arterial hypertension, immunoglobulin for primary immune deficiency, insulin for diabetes, antifungals, antivirals, and narcotics to treat severe pain unrelieved by other methods, and chemotherapy, with modifier KD. Append this modifier to drug and biological codes administered via the above routes through an infusion pump. The medical documentation must illustrate that a medically necessary drug is administered via an implanted DME, i.e., an infusion pump.
KE	**Bid under round one of the DMEPOS competitive bidding program for use with non-competitive bid base equipment** **Definition:** Append modifier KE to codes for competitively bid wheelchair accessory claims when the accessory will be used with a noncompetitive bid wheelchair. **Explanation:** Append this modifier to codes for accessory items to be used with a noncompetitive bid base item. The modifier indicates an accessory code that can be billed with either competitive or noncompetitive base items when the accessory is to be used with a noncompetitive bid item. The competitive bidding program sets payment amounts for certain durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS to reduce beneficiary copays and save Medicare money while ensuring beneficiary access to quality items and services. **Tips:** The KE modifier is a pricing modifier that suppliers must use to identify when the same accessory HCPCS code can be furnished in multiple competitive and noncompetitive bidding product categories. For competitively bid accessories used with competitively bid base equipment supplied to beneficiaries living in competitive bid areas, the supplier should submit modifier KG, DMEPOS item subject to DMEPOS competitive bidding program number one, or KK, DMEPOS item subject to DMEPOS competitive bidding program number two, as appropriate.

Mod	Modifier Description, Definition, Explanation, and Tips
KF	**Item designated by FDA as class III device** **Definition:** Append modifier KF to a code for a device that the Food and Drug Administration, or FDA, has designated as a class III device. **Explanation:** Append this modifier for durable medical equipment designated as a class III device by the FDA. This pricing modifier identifies class III devices on the durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS, fee schedule. Append modifier KF with claims for investigational FDA designated class III devices, such as intraspinal catheter with infusion pump, electrodes of an external defibrillator, stair climbing power wheelchairs, and other devices. Class III devices are investigational devices still in clinical trials. The FDA designates as Class III those devices which cannot be classified into class I, i.e., those subject only to general controls, such as good manufacturing practice regulations, or class II, i.e., those which require additional performance review or postmarket surveillance to assure safety and effectiveness, because insufficient information exists to determine safety and effectiveness. These devices require FDA premarket approval to be released in the market. The FDA designates class III devices as category A for which initial questions of safety and effectiveness have not been resolved and the FDA is unsure whether the device type is safe and effective or category B which the FDA believes to be class I or II type devices for which underlying questions of safety and effectiveness have been resolved or safety and effectiveness have been demonstrated because other manufacturers have obtained FDA approval for that device type. Medicare does not pay for category A devices. The provider participating in the clinical trial must furnish all necessary information concerning the device, the clinical trial, and participating Medicare beneficiaries that the contractor deems necessary for a coverage determination and claims processing. Medicare contractors make the coverage determinations on all FDA approved category B devices by applying Medicare's longstanding criteria and procedures for making coverage decisions. Coverage decisions should be made for FDA approved investigational device exemptions, or IDEs, as they currently are made for FDA approved devices.
KG	**DMEPOS item subject to DMEPOS competitive bidding program number 1** **Definition:** Append modifier KG to a code for a claim for durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS, which the supplier provides in a multiple competitive bidding product category for a standard product category. **Explanation:** Append this modifier when the supplier delivers the same DMEPOS item in multiple competitive bidding product categories for a standard product category. The competitive bidding program sets payment amounts for certain durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS to reduce beneficiary copays and save Medicare money while ensuring beneficiary access to quality items and services. **Tips:** Failure to report this modifier may result in claim denial, Medicare overpayments, and other penalties that may lead to termination of the contract. The KG and KK modifiers are used in the round one rebid of the competitive bidding program as pricing modifiers and the KU and KW modifiers are reserved for future program use. The modifier KY indicates a claim for a beneficiary who resides in a competitive bidding area and purchases accessories and supplies for use with durable medical equipment. The competitive bidding program includes nine DMEPOS product categories; the number in the descriptor is the round number and indicates an expansion of the program to designated geographical boundaries. These modifiers are described as follows: KG: DMEPOS item subject to DMEPOS competitive bidding program number one. KK: DMEPOS item subject to DMEPOS competitive bidding program number two. KU: DMEPOS item subject to DMEPOS competitive bidding program number three. KW: DMEPOS item subject to DMEPOS competitive bidding program number four. KY: DMEPOS item subject to DMEPOS competitive bidding program number five.
KH	**DMEPOS item, initial claim, purchase or first month rental** **Definition:** Append modifier KH to the code for a claim for the first rental month or purchase option of durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS. The beneficiary may decide to purchase the item at any time during the rental period. **Explanation:** Append this modifier to DMEPOS claims for the first month of a capped rental period. Capped rental involves the payment of rent for 13 consecutive months to the supplier of the item, while the beneficiary uses the equipment. It covers all the costs including reasonable repairs, maintenance, replacement, or other costs. **Tips:** You should append the modifier KH with modifier RR, Rental; use the RR modifier when DME is to be rented. The KH modifier may also be used in conjunction with HCPCS modifier NU, New equipment, and UE, Used durable medical equipment. These modifiers do not need to be submitted on claims for oxygen and oxygen equipment.

Mod	Modifier Description, Definition, Explanation, and Tips
KI	**DMEPOS item, second or third month rental** **Definition:** Append modifier KI to identify the second or third rental month or purchase option for durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS. The beneficiary may decide to purchase the item at any time of the rental period. **Explanation:** Append this modifier to DMEPOS claims for the second or third month of the capped rental period. Capped rental involves the payment of rent for 13 consecutive months to the supplier of the item, while the beneficiary uses the equipment. It covers all the costs including reasonable repairs, maintenance, replacement, or other costs. **Tips:** Use the modifier KI for the second or third month's rent of the DMEPOS items. You should append the modifier KI with modifier RR, Rental; use the RR modifier when DME is to be rented. These modifiers do not need to be submitted on claims for oxygen and oxygen equipment. For the first month rental period, use modifier KH, DMEPOS item, initial claim, purchase or first month rental. If the rental period continues past the third month, append modifier KJ, DMEPOS item, parenteral enteral nutrition, pen, pump or capped rental, months four to 15.
KJ	**DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months four to fifteen** **Definition:** Append modifier KJ to identify the fourth to 15th rental month purchase option for durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS; parenteral enteral nutrition pump rental, or capped rental. The beneficiary may purchase the item at any time of the rental period. **Explanation:** Append this modifier to DMEPOS, parenteral enteral nutrition pump, or capped rental claims for the fourth to 15th month of the capped rental period. Capped rental involves the payment of rent for 13 consecutive months to the supplier of the item, while the beneficiary uses the DMEPOS equipment and up to 15 months for parenteral enteral nutrition pump or other capped rental items. It covers all the costs including reasonable repairs, maintenance, replacement, or other costs. **Tips:** Use modifier KJ for each month of rental past the third month and up to the 13th month for DMEPOS items and up to the 15th month for a parenteral enteral nutrition pump. You should append the modifier KJ with modifier RR, Rental; use the RR modifier when DME is to be rented. These modifiers do not need to be submitted on claims for oxygen and oxygen equipment. For the first month rental period, use modifier KH, DMEPOS item, initial claim, purchase or first month rental, and for the second and third rental months, append modifier KI, DMEPOS item, second or third month rental.
KK	**DMEPOS item subject to DMEPOS competitive bidding program number 2** **Definition:** Append modifier KK to code for durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS, which the supplier provides in a multiple competitive bidding product category for a complex product category. **Explanation:** Append this modifier when the supplier delivers the same DMEPOS item in multiple competitive bidding product categories for a complex product category. The competitive bidding program sets payment amounts for certain durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS to reduce beneficiary copays and save Medicare money while ensuring beneficiary access to quality items and services. **Tips:** Modifier KK is a pricing modifier for DMEPOS item claims that the supplier provides the beneficiary. Failure to report this modifier may result in claim denial, Medicare overpayments, and other penalties that may lead to termination of the contract. The KG and KK modifiers are used in the round one rebid of the competitive bidding program as pricing modifiers and the KU and KW modifiers are reserved for future program use. The modifier KY indicates a claim for a beneficiary who resides in a competitive bidding area and purchases accessories and supplies for use with durable medical equipment. The competitive bidding program includes nine DMEPOS product categories; the number in the descriptor is the round number and indicates an expansion of the program to designated geographical boundaries. These modifiers are described as follows: KG: DMEPOS item subject to DMEPOS competitive bidding program number one. KK: DMEPOS item subject to DMEPOS competitive bidding program number two. KU: DMEPOS item subject to DMEPOS competitive bidding program number three. KW: DMEPOS item subject to DMEPOS competitive bidding program number four. KY: DMEPOS item subject to DMEPOS competitive bidding program number five.

Mod	Modifier Description, Definition, Explanation, and Tips
KL	**DMEPOS item delivered via mail** **Definition:** Append modifier KL to the claim for a mail order supply of durable medical equipments, prosthetics, orthotics, and supplies, or DMEPOS. **Explanation:** Append this modifier to indicate that the DMEPOS supplies were delivered to the beneficiary's residence through the mail and not from a local supplier storefront. Currently, this modifier applies to claims for only diabetic supply codes that a beneficiary receives through mail order. **Tips:** Failure to report this modifier may result in claim denial, Medicare overpayments, and other penalties that may lead to termination of the contract.
KM	**Replacement of facial prosthesis including new impression/moulage** **Definition:** Append modifier KM to the claim for the fabrication of any replacement of a prosthesis for any part of the face; this includes a new impression or mold, i.e., a moulage, of the face to be treated with the prosthesis. **Explanation:** Append this modifier to the claim for the replacement of a facial prosthesis; this includes the mold or impression if the provider needs one to fabricate the prosthesis, so do not bill the mold separately. **Tips:** If the provider uses a previously created mold to fabricate the replacement facial prosthesis, append modifier KN, Replacement of facial prosthesis using previous master model. Modifiers KM and KN must be appended to claims for replacement of facial prostheses provided by a nonphysician reported with codes L8040 through L8047. These codes include prosthetic procedures over various regions of the face like nasal prosthesis, midfacial prosthesis, orbital prosthesis, and others.
KN	**Replacement of facial prosthesis using previous master model** **Definition:** Append modifier KN to the claim for the fabrication of any replacement prosthesis for any part of the face that the provider fabricated using a previously created mold. **Explanation:** Append this modifier to the claim for a replacement facial prosthesis when the provider uses a previously created mold to fabricate the prosthesis. **Tips:** If the provider uses a new impression or mold of the face to replace a facial prosthesis, append modifier KM, Replacement of facial prosthesis including new impression or moulage. Modifiers KM and KN must be appended to claims for replacement of facial prostheses provided by a nonphysician reported with codes L8040 through L8047. These codes include prosthetic procedures over various regions of the face like nasal prosthesis, midfacial prosthesis, orbital prosthesis, and others.
KO	**Single drug unit dose formulation** **Definition:** Append modifier KO to the code for a single drug supplied in a unit dose container, which the provider administers to a patient. **Explanation:** Append this modifier to a drug code to show that the provider administers a single drug that was supplied as a unit dose to the patient. **Tips:** Do not append this modifier to drug codes that are not supplied in a unit dose vial or container. Drugs supplied in unit dose form consist of inhalation drugs administered via a device classified as durable medical equipment, or DME. However, do not append modifier KO to J2545, Pentamidine isethionate, inhalation solution, FDA approved final product, noncompounded, administered through DME, unit dose form, per 300 mg or Q4074, Iloprost, inhalation solution, FDA approved final product, noncompounded, administered through DME, unit dose form, up to 20 mcg. Do not append the modifier to codes for the concentrated form of a drug. If the provider dispenses the first drug of the multiple drug in unit dose, append modifier KP, First drug of a multiple drug unit dose formulation. If the provider dispenses second or subsequent dose of a multiple drug in unit dose, append modifier KQ, Second or subsequent drug of a multiple drug unit dose formulation. If you do not append modifier KO, KP, or KQ to a code for a unit dose of a drug, Medicare will deny the claim.

Mod	Modifier Description, Definition, Explanation, and Tips
KP	**First drug of a multiple drug unit dose formulation** **Definition:** Append modifier KP to the drug code for the first drug that the provider includes in a multiple drug formulation compounded from drugs supplied in a unit dose form or for the first dose of a single drug supplied in a unit dose form when the total dose is greater than the amount supplied in a single vial or container. **Explanation:** Append this modifier to a code for the first drug that that the provider uses to compound a multiple drug unit dose formulation composed of more than one drug dispensed in a unit dose form. Also, append this modifier to the code for the first dose of a drug when the provider administers a single drug in a dose greater than the amount supplied in the unit dose form. **Tips:** Do not append this modifier to drug codes that are not supplied in a unit dose vial or container. Do not append the modifier to drug codes for a concentrated form of the drug. For the first dose, when the provider compounds a multiple drug formulation from two or more drugs dispensed in single drug unit form or when the provider administers a larger dose of a drug than that supplied in single unit dose form, append modifier KQ, Second or subsequent drug of a multiple drug unit dose formulation. If more than two drugs are compounded from drugs dispensed in unit dose form, no modifier is appended to the codes for the additional drugs. If the provider dispenses a unit dose of a single drug, append modifier KO, Single drug unit dose formulation. Use the modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded in order to receive payment for the amount of discarded drug or biological. If you do not append modifier KO, KP, or KQ to a code for a unit dose of a drug, Medicare will deny the claim.
KQ	**Second or subsequent drug of a multiple drug unit dose formulation** **Definition:** Append modifier KQ to the drug code for the second drug that the provider includes in a multiple drug formulation compounded from drugs supplied in a unit dose form or for the second dose of a single drug supplied in a unit dose form when the total dose is greater than the amount supplied in a single vial or container. **Explanation:** Append this modifier to a code for the second drug that that the provider uses to compound a multiple drug unit dose formulation composed of more than one drug dispensed in a unit dose form. Also, append this modifier to the code for the second dose of a drug when the provider administers a single drug in a dose greater than the amount supplied in the unit dose form. **Tips:** Do not append this modifier to drug codes that are not supplied in a unit dose vial or container. Do not append the modifier to drug codes for a concentrated form of the drug. For the first dose, when the provider compounds a multiple drug formulation from two or more drugs dispensed in single drug unit form or when the provider administers a larger dose of a drug than that supplied in single unit dose form, append modifier KP, First drug of a multiple drug unit dose formulation. If more than two drugs are compounded from drugs dispensed in unit dose form, no modifier is appended to the codes for the additional drugs. If the provider dispenses a unit dose of a single drug, append modifier KO, Single drug unit dose formulation. Use the modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded in order to receive payment for the amount of discarded drug or biological. If you do not append modifier KO, KP, or KQ to a code for a unit dose of a drug, Medicare will deny the claim.
KR	**Rental item, billing for partial month** **Definition:** Append modifier KR to the code for a claim for a partial month rental for durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS. **Explanation:** Append this modifier to DMEPOS claims for a partial month of the capped rental period. The supplier submits the code for a month's rental of the DMEPOS and appends this modifier when the rental period was less than the month claimed. Capped rental involves the payment of rent for 13 consecutive months to the supplier of the item, while the beneficiary uses the equipment. It covers all the costs including reasonable repairs, maintenance, replacement, or other costs. **Tips:** You should append the modifier KR with modifier RR, Rental; use the RR modifier when DME is to be rented. For the first month rental period, use modifier KH, DMEPOS item, initial claim, purchase or first month rental. If the rental period continues to a second or third rental month, append modifier KI, DMEPOS item, second or third month rental. If the rental period continues for a fourth to 15th month, append modifier KJ, DMEPOS item, parenteral enteral nutrition, pen, pump or capped rental, months four to 15.

Mod	Modifier Description, Definition, Explanation, and Tips
KS	**Glucose monitor supply for diabetic beneficiary not treated with insulin** **Definition:** Append modifier KS when the provider supplies a glucose monitor to a patient who is not being treated with insulin injections. **Explanation:** The provider appends modifier KS when he dispenses all diabetic supplies to a patient per his order. The documentation must include the diagnosis of diabetes in order for the supplies to be covered. Append modifier KS on every claim for a glucose monitor and related supplies for patients not receiving insulin injections. **Tips:** The provider must have a record for the supplies that exceed the utilization guideline. New documentation should be presented at least every six months if the patient regularly uses the supplies.
KT	**Beneficiary resides in a competitive bidding area and travels outside that competitive bidding area and receives a competitive bid item** **Definition:** Append modifier KT when a beneficiary residing in a competitive bidding area, or CBA, receives a competitive bid item while traveling outside that competitive bidding area. **Explanation:** The supplier appends modifier KT for competitive bidding items, such as durable medical equipment, prosthetics, orthotics, and similar supplies, or DMEPOS, which he supplies to beneficiaries traveling outside the CBA in which they reside. Append the KT modifier to claims for nonmail order durable medical equipment, prosthetics, orthotics, and supplies when supplying these items to beneficiaries who require these items when traveling outside their resident CBA. If a CBA resident obtains a CBA item in a nonCBA area while traveling, the noncontract supplier must append modifier KT to the claim. Similarly, if a CBA resident obtains a CBA item from a contract supplier in a different CBA, the contract CBA supplier must append modifier KT to the claim. **Tips:** Important questions that need to be answered when a beneficiary needs a competitively bid item while traveling include the following: Is the beneficiary's permanent residence inside or outside a CBA? To verify a beneficiary's permanent CBA address, enter the beneficiary's permanent residence ZIP code into the CBA finder tool on the home page of the competitive bidding implementation contractor, or CBIC. Is the item being obtained inside or outside a CBA? If the beneficiary whose permanent address is inside a CBA travels to another CBA and the required item is a competitively bid item, the beneficiary must obtain the item from a CBA contractor who must append modifier KT to the claim. If the beneficiary needs a noncompetitive bid item, any Medicare enrolled supplier can provide the item. If the beneficiary whose permanent address is inside a CBA travels to nonCBA and needs a competitive bid item, the beneficiary may obtain the item from any Medicare enrolled supplier, and the supplier must affix the KT modifier to the claim. If the beneficiary's permanent residence is not in a CBA and the beneficiary travels to a CBA and requires a competitive bid item, the beneficiary must obtain the item from a contract supplier for the area where he or she is visiting. If the beneficiary needs a nonbid item, he or she may obtain the item from any Medicare enrolled supplier. In both cases, the supplier will be paid the fee schedule amount for the area where the patient permanently resides. If the beneficiary's permanent residence is not in a CBA and the beneficiary travels to an area that is not in a CBA and requires a competitive bid item, the beneficiary may obtain the item from any Medicare enrolled supplier. The supplier will be paid the fee schedule amount for the state where the beneficiary permanently resides. Claims submitted without the KT modifier by skilled nursing facilities, or SNFs, and other nursing facilities that are not located in a CBA and are not contract suppliers will be denied for residents who receive enteral nutrition items while in the facility if their permanent home address is in a CBA. Mail order CBA diabetic supplies claims with the KT modifier will be denied for traveling beneficiaries unless the supplies are shipped to the beneficiary's permanent CBA home address.

Mod	Modifier Description, Definition, Explanation, and Tips
KU	**DMEPOS item subject to DMEPOS competitive bidding program number 3** **Definition:** Append this modifier to indicate a durable medical equipment item depending upon the DMEPOS competitive bidding program number three, i.e., reserved for future program use. **Explanation:** Append modifier KU when the supplier supplies the same durable medical equipment, prosthetics, orthotics, and similar supplies, or DMEPOS, in multiple competitive bidding product categories or when the same code can be used to describe both competitively and noncompetitively bid items. The KU modifier is reserved for future use. **Tips:** The KG, KK, KU and KW modifiers are pricing modifiers that identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories or when the same code can be used to describe both competitively and noncompetitively bid items. The KG and KK modifiers are used in the Round I Rebid of the competitive bidding program as pricing modifiers and the KU and KW modifiers are reserved for future program use. The competitive bid modifiers KG, KK, KU, and KW are only used on claims for beneficiaries that live in a Competitive Bidding Area, or CBA. Competitive Bidding Program pricing modifiers KE, KG, KK, KU, KW, or KY, NU, RR or UE modifier should be placed in the first position following the HCPCS code and the KE modifier should be placed in the second position.
KV	**DMEPOS item subject to DMEPOS competitive bidding program that is furnished as part of a professional service** **Definition:** Append modifier KV, when professional providers, who are not contract suppliers, supply walkers and related accessories to beneficiaries in a competitive bidding area or CBA. **Explanation:** The noncontract professional provider appends modifier KV when he or she supplies walkers and other accessories to beneficiaries in a competitive bidding area or CBA. Contract suppliers should not append modifier KV. **Tips:** Walkers that are appropriately supplied in accordance with this exception will be paid at the single payment amount. The provider, as a noncontract supplier, should append modifier KV in combination with the following HCPCS codes: A4636, Replacement, handgrip, cane, crutch, or walker, each; A4637, Replacement, tip, cane, crutch, walker, each; and E0130 to E0159 for walkers and replacement parts. On the claim billed to the Durable Medical Equipment Medicare Administrative Contractor or DME MAC, the walker line item must have the same date of service as the professional service office visit billed to the Part A or Part B MAC. The provider and treating practitioners should submit the office visit claim and the walker claim on the same day to ensure timely and accurate claims processing.
KW	**DMEPOS item subject to DMEPOS competitive bidding program number 4** **Definition:** Append this modifier to indicate a durable medical equipment item depending upon the DMEPOS competitive bidding program number four, i.e., reserved for future program use. **Explanation:** Append modifier KW when the supplier supplies the same DMEPOS item in multiple competitive bidding product categories. This modifier is reserved for future use. **Tips:** The KG, KK, KU and KW modifiers are pricing modifiers that identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories or when the same code can be used to describe both competitively and noncompetitively bid items. The KG and KK modifiers are used in the Round I Rebid of the competitive bidding program as pricing modifiers and the KU and KW modifiers are reserved for future program use. The competitive bid modifiers, KG, KK, KU, and KW, are only used on claims for beneficiaries that live in a Competitive Bidding Area, or CBA. Competitive Bidding Program pricing modifiers KE, KG, KK, KU, KW, or KY, the NU, RR or UE modifier should be placed in the first position following the HCPCS code and the KE modifier should be placed in the second position.

Mod	Modifier Description, Definition, Explanation, and Tips
KX	**Requirements specified in the medical policy have been met** **Definition:** The provider should append modifier KX when exceptions are in effect and the beneficiary qualifies for an exception. **Explanation:** Modifier KX is a multipurpose modifier for part B professional services claims to over-ride therapy caps for physical therapy, occupational therapy or speech language pathology services, for certain DMEPOS services, and to bypass gender-specific (services identified as male or female) edits for patients with ambiguous genitalia and transgender patients. Appending modifier KX affirms that the documentation supports the requirements stated in the medical policy have been met and that the service was medically necessary. For example, you may append modifier KX on claims for physical therapy, occupational therapy or speech language pathology services when therapy exceeds the caps listed in the medical policy. When you append modifier KX, it means that the provider attests that the requirements in the medical policy that relate to therapy cap exceptions have been met. In addition, it means the medical record documents that the additional therapy was medically necessary. The beneficiary may qualify for use of the cap exceptions at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps. All requests for exception require that the KX modifier be added to the claim. DME example: Append KX to codes for the supply of glucose monitors and testing supplies when the patient is receiving insulin injections. By appending the KX modifier, the provider attests that the services billed are reasonable and necessary services, that they meet the policy requirements, that the medical record justifies the services, and that they qualify for an exception using the automatic process exception. **Tips:** The following CPT® codes for evaluation procedures may qualify for requests for an exception with the addition of modifier KX: 97161-97172. If physical therapy, occupational therapy, or speech language pathology services would be payable before the cap is reached and can be justified as still medically necessary after the cap is reached, that service should be covered. Contact your contractor for interpretation if you are not sure that a service qualifies for an exception. It is very important to recognize that most conditions would not ordinarily result in services exceeding the cap. Use the KX modifier only when therapy that exceeds the cap can be justified and documented. Routine use of the KX modifier for all patients with these conditions will likely show up on data analysis as aberrant and invite inquiry. Ensure that the medical record includes sufficient detail to support the use of the modifier. Documentation does not have to provided unless requested, however. In addition to its other existing uses, modifier KX should also be used to identify services that are gender-specific, i.e., services that are considered female or male only, which includes transgender patients or patients with ambiguous genitalia; that the physician or 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. Justification for exceptions to therapy caps includes medical diagnoses and complications that might directly and significantly influence the amount of treatment required. Other variables, such as the availability of a caregiver at home, that affect appropriate treatment may also justify an exception. Published research, clinical guidelines from professional sources, and or clinical or common sense should support the request for an exception to therapy caps. The patient's lack of access to outpatient hospital therapy services alone, when outpatient hospital therapy services are excluded from the limitation, does not constitute justification for exceptions to therapy caps. Residents of skilled nursing facilities prevented by consolidated billing from accessing hospital services, debilitated patients for whom transportation to the hospital is a physical hardship, or lack of therapy services at hospitals in the beneficiary's county may or may not qualify as justification for continued services above the caps. The patient's condition and complexities might justify extended services, but their location does not. Note: Append KX to bypass gender-specific code requirements on Part B claims. For Part A claims, append condition code 45 (Ambiguous Gender Category) on any outpatient claim related to transgender or hermaphrodite issues.

Mod	Modifier Description, Definition, Explanation, and Tips
KY	**DMEPOS item subject to DMEPOS competitive bidding program number 5** **Definition:** Append modifier KY to codes for a claim for competitive bid, or CB, wheelchair accessories in the durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS, competitive bidding program number five. **Explanation:** Append this modifier when the supplier delivers the same DMEPOS item in multiple competitive bidding product categories for complex product category. The KY modifier should only be appended to competitive bid, or CB, wheelchair accessories. The competitive bidding program sets payment amounts for certain durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS to reduce beneficiary copays and save Medicare money while ensuring beneficiary access to quality items and services. **Tips:** Failure to report this modifier may result in claim denial, Medicare overpayments, and other penalties that may lead to termination of the contract. The KG and KK modifiers are used in the round one rebid of the competitive bidding program as pricing modifiers and the KU and KW modifiers are reserved for future program use. The modifier KY indicates a claim for a beneficiary who resides in a competitive bidding area and purchases accessories and supplies for use with durable medical equipment. The competitive bidding program includes nine DMEPOS product categories; the number in the descriptor is the round number and indicates an expansion of the program to designated geographical boundaries. These modifiers are described as follows: KG: DMEPOS item subject to DMEPOS competitive bidding program number one. KK: DMEPOS item subject to DMEPOS competitive bidding program number two. KU: DMEPOS item subject to DMEPOS competitive bidding program number three. KW: DMEPOS item subject to DMEPOS competitive bidding program number four. KY: DMEPOS item subject to DMEPOS competitive bidding program number five.
KZ	**New coverage not implemented by managed care** **Definition:** Append modifier KZ when the provider implants a defibrillator in a patient for a new indication not previously included in managed care or Medicare Advantage plan guidelines for implantation of a defibrillator. **Explanation:** Append modifier KZ to the claim when the provider implants a cardioverter defibrillator, or ICD, based on an indication or condition not previously included in managed care guidelines. Append modifier KZ to codes for ICDs placed on Medicare Managed Care claims for the new coverage guidelines. However, make sure you report implants performed under the older guidelines without this modifier. Medicare does not require an advanced beneficiary notice or ABN to reimburse the services given by the provider. **Tips:** CPT® codes to which HCPCS modifier KZ may be appended include 33240 through 33241; 33243 and 33244; 33249 and 33979.
LC	**Left circumflex coronary artery** **Definition:** Append modifier LC to a code for procedures on the left circumflex coronary artery. **Explanation:** Append this modifier to codes when the provider performs a procedure on the left circumflex coronary artery. The left circumflex coronary artery supplies blood to the left atrium and left ventricle of the heart, i.e., the upper and the lower chambers of the heart respectively. **Tips:** The various types of procedures on the left circumflex coronary artery include angioplasty, atherectomy, stent placement, or grafting. If the provider performs a procedure on the right coronary artery, append modifier RC, right coronary artery. If the provider performs a procedure on the left anterior descending artery, use modifier LD, Left anterior descending coronary artery. If the provider targets the left main coronary artery, use modifier LM, Left main coronary artery. If the provider performs a procedure on ramus intermedius coronary artery, use modifier RI, Ramus intermedius coronary artery.

Mod	Modifier Description, Definition, Explanation, and Tips
LD	**Left anterior descending coronary artery** **Definition:** Append modifier LD to a code for procedures on the left anterior descending coronary artery. **Explanation:** Append this modifier to codes when the provider performs a procedure on the left anterior descending coronary artery, also known as the anterior interventricular artery. The left anterior descending coronary artery supplies blood to the left ventricle, the left lower chamber of the heart that pumps blood out of the heart to the rest of the body. **Tips:** The various types of procedures on the left anterior descending coronary artery include angioplasty, atherectomy, stent placement, or grafting. If the provider performs a procedure on the right coronary artery, append modifier RC, right coronary artery. If the provider performs a procedure on the left circumflex coronary artery, append modifier LC, left circumflex coronary artery. If the provider targets the left main coronary artery, use modifier LM, Left main coronary artery. If the provider performs a procedure on ramus intermedius coronary artery, use modifier RI, Ramus intermedius coronary artery.
LL	**Lease/rental (use the 'll' modifier when DME equipment rental is to be applied against the purchase price)** **Definition:** A provider appends modifier LL to durable medical equipment, or DME, rental items that he applies the rental payments against the purchase price. DME is medical equipment that helps a patient to manage his activities of daily living, or ADL, in an easier way or that provides therapeutic benefits to a patient. **Explanation:** A provider appends modifier LL to codes for DME rental that he applies the rental payments against the purchase price for the item. DME helps the patient to manage his activities of daily living in an easier way. A few examples of DME's are crutches, wheelchairs, commodes, canes, walkers, hospital beds, patient safety equipment, and fracture and traction apparatus. **Tips:** A provider uses modifier RR, Rented item, if the DME item is being rented by the patient, modifier NU, New purchased item, if the DME item is purchased new by the patient, and modifier NR, New when rented, when the DME, which was new at the time of rental is subsequently purchased.
LM	**Left main coronary artery** **Definition:** Append modifier LM to a code for procedures on the left main coronary artery. **Explanation:** Append this modifier to codes when the provider performs a procedure on the left main coronary artery. The left main coronary artery supplies blood to a large portion of the heart and the arteries branching off the heart. **Tips:** The various types of procedures on the left main coronary artery include angioplasty, atherectomy, stent placement, or grafting. If the provider performs a procedure on the right coronary artery, append modifier RC, right coronary artery. If the provider performs a procedure on the left circumflex coronary artery, append modifier LC, left circumflex coronary artery. If the provider performs a procedure on the left anterior descending artery, use modifier LD, Left anterior descending coronary artery. If the provider performs a procedure on ramus intermedius coronary artery, use modifier RI, Ramus intermedius coronary artery.
LR	**Laboratory round trip** **Definition:** Append modifier LR to a code for travel costs involved with obtaining a diagnostic laboratory service from either a nursing home patient or homebound patient. **Explanation:** Modifier LR identifies a code for a diagnostic or a laboratory procedure that requires round trip travel to acquire the specimen. The provider identifies the round trip travel by use of the LR modifier. Independent clinical laboratories may append this modifier to a HCPCS code such as P9604, Travel allowance one way in connection with a medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated trip charge. **Tips:** Not using modifier LR should have no effect on payment.
LS	**FDA-monitored intraocular lens implant** **Definition:** Append modifier LS to a code for a patient undergoing surgery and fitted with an intraocular lens implant, or IOL. **Explanation:** Modifier LS illustrates a code for a patient undergoing surgery and fitting with an intraocular lens implant, or IOL. The provider surgically places an intraocular lens in the eye of a patient with eye disorders such as cataracts or myopia. A cataract is an eye condition in which the lens of the eye becomes opaque gradually, leading to blurred vision. Myopia causes the patient to lose focus of distant objects, and he is only able to see nearby objects clearly. Modifier LS provides additional information to the payer when billing eye procedures that the provider places an IOL that is being monitored by the Food and Drug Administration, or FDA. **Tips:** Append this modifier on provider claims for eye surgery in patients with IOL implants.

Mod	Modifier Description, Definition, Explanation, and Tips
LT	**Left side (used to identify procedures performed on the left side of the body)** **Definition:** Append modifier LT to specify the procedure that the provider performs is on the left side of the body. **Explanation:** Modifier LT illustrates that a provider performs a procedure on the left side of a patient's body. LT represents the left anatomical side of the body, when the body contains the same anatomical part on both the right and left side of the body. The provider applies LT in the case of procedures he performs on the left side of a paired organ such as the kidneys, lungs, legs, or ears. A provider does not append this modifier when a procedure code specifies bilateral, or modifier 50, Bilateral Procedure, as they are not compatible or if the code specifies a particular side of the body. **Tips:** Modifier LT does not affect the allowed amount on a claim; however, lack of the modifier can lead to denials. Some private payers do not recognize the LT and RT, Right side modifiers. For these procedures, a provider may use a single code with modifier 50, Bilateral Procedure, to denote a bilateral procedure. When using more than one modifier, place a pricing modifier, or a modifier that affects reimbursement, in the first modifier position. Then place the informational modifier in the second modifier position. For example if a provider uses a procedure code with modifier 22, Increased Procedural Services and modifier LT, then place modifier 22 first and modifier LT second.
LU	**Fractionated payment** **Definition:** Append modifier LU to a code to alert the payer that you are reporting fractional units for a single procedure or service to allow accurate payment. **Explanation:** Append this modifier to a code to indicate to the payer that you are reporting a single procedure or service using fractionated units, as defined by the payer. For instance, the code descriptor may state "per therapeutic dose, " but a contractor may have a rule to divide the allowed total payment by 10, requiring the provider to bill in 0.1 unit fractions. The provider would then bill a total of 10 fractional units to reach the total allowed payment amount of 1 unit. Note that this is only an example of a possible rule. Instructions may vary based on the individual payer. This modifier may be appropriate when a claim system's field length is not long enough for the price for a service. Providers can use modifier LU to bill fractional units of a single service so the claim reflects the total dollar amount. **Tips:** Check individual payer and contractor reporting rules regarding proper use of this modifier, as rules may vary.
M2	**Medicare secondary payer (MSP)** **Definition:** Append modifier M2 to specify that Medicare is the secondary payer for a drug procured outside of the Competitive Acquisition Program, or CAP, for drugs and biological. **Explanation:** The M2 modifier is only for the submission of claims by providers, enrolled in the Competitive Acquisition Program, or CAP, for drugs and biological, an alternative reimbursement methodology to the Average Sales Price, or ASP payment method. The provider appends this modifier when he incorrectly identifies the patient's main insurer and procures a CAP drug for a Medicare patient from a source other than the CAP vendor. The CAP provider later determines that Medicare is primary and that the drug should have been ordered through the approved CAP vendor. The provider appends the M2 modifier to the drug, which allows the local carrier's claims processing system to make a payment under ASP. The participating CAP provider maintains documentation in the beneficiary's medical record to provide further information if necessary as to why they made the initial determination that Medicare is secondary to another payer. The local carrier may request this documentation for review purposes. **Tips:** Modifier M2 is no longer effective for services after December 31, 2008.
MS	**Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty** **Definition:** Append modifier MS to a code to identify the service is for a six month periodic, in home visit by the provider for inspection and servicing of equipment. The service the provider performs includes the general maintenance and servicing to the item as well as costs not covered by a manufacturer or supplier warranty for reasonable and necessary parts to service the equipment. **Explanation:** Modifier MS illustrates a code for the routine maintenance and performance checks a provider performs every six months on DME, or durable medical equipment such as oxygen equipment. This maintenance and servicing typically includes the labor time spent and any reasonable and necessary parts he uses to keep the equipment in good working order, and which are not covered under any manufacturer or supplier warranty. The provider appends this modifier to Healthcare Common Procedure Coding System, or HCPCS, codes such as oxygen concentrator codes E1390 to E1392, and K0738, Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing. **Tips:** Medicare no longer pays for maintenance and servicing of capped rental items every six months with the exception of oxygen equipment. For other capped rental items, Medicare typically covers reasonable and necessary repairs and servicing once the beneficiary owns the capped rental item.

Mod	Modifier Description, Definition, Explanation, and Tips
N1	**Group 1 oxygen coverage criteria met** **Definition:** Append modifier N1 to indicate the service meets group 1 oxygen coverage criteria for the payer. **Explanation:** Append modifier N1 to indicate the service meets group 1 oxygen therapy coverage criteria as defined by the payer for the relevant date of service. Factors may include the patient's PO2 (partial pressure of oxygen, which is the amount of oxygen gas dissolved in the blood) and specific diagnoses.
N2	**Group 2 oxygen coverage criteria met** **Definition:** Append modifier N2 to indicate the service meets group 2 oxygen coverage criteria for the payer. **Explanation:** Append modifier N2 to indicate the service meets group 2 oxygen therapy coverage criteria as defined by the payer for the relevant date of service. Factors may include the patient's PO2 (partial pressure of oxygen, which is the amount of oxygen gas dissolved in the blood) and specific diagnoses.
N3	**Group 3 oxygen coverage criteria met** **Definition:** Append modifier N3 to indicate the service meets group 3oxygen coverage criteria for the payer. **Explanation:** Append modifier N3 to indicate the service meets group 3 oxygen therapy coverage criteria as defined by the payer for the relevant date of service. Factors may include the patient's PO2 (partial pressure of oxygen, which is the amount of oxygen gas dissolved in the blood) and specific diagnoses.
NB	**Nebulizer system, any type, FDA-cleared for use with specific drug** **Definition:** Append modifier NB to a code for any type of nebulizer system that is cleared by the Food and Drug Administration, or FDA, for use with specific drugs. **Explanation:** Modifier NB illustrates the use of a nebulizer system of any type. The nebulizer system that the provider appends the modifier to is a system cleared by the Food and Drug Administration, or FDA, for use with specific drugs. This modifier may be applicable to Healthcare Common Procedure Coding System, or HCPCS, codes E0550 through E0585, which identify different types of nebulizer systems. **Tips:** Append this modifier for Medicare services that the facility submits to a durable medical equipment, or DME Medicare Administrative Contractor, a DME MAC.
NR	**New when rented (use the 'NR' modifier when DME which was new at the time of rental is subsequently purchased)** **Definition:** A provider appends modifier NR to identify durable medical equipment, or DME, that was new at the time of rental, and a patient subsequently purchases it. DME is medical equipment that helps a patient to manage his activities of daily living in an easier way or that provides therapeutic benefits to a patient. **Explanation:** A provider appends modifier NR to a code to indicate that a DME item that the patient purchases was new DME when the patient first received the item at the time of rental. DME helps the patient to manage his activities of daily living in an easier way. A few examples of DME's are crutches, wheelchairs, commodes, canes, walkers, hospital beds, patient safety equipment, and fracture and traction apparatus. **Tips:** A provider uses the modifier RR, Rented item, if the item is being rented by the patient and modifier NU, New purchased item, if the item is purchased new by the patient.
NU	**New equipment** **Definition:** Append modifier NU to a code for new durable medical equipment item. **Explanation:** Modifier NU identifies that the beneficiary has received new or fresh durable medical equipment, or DME, that is equipment which has never been used before. The DME codes the provider may most often append this modifier to, are items that are inexpensive or routinely purchased items, capped rental items, items requiring frequent and substantial servicing, or oxygen equipment. The codes that may apply include HCPCS E codes and K codes items including complex rehabilitative power wheelchairs, K0835 through K0891. **Tips:** Append this modifier to identify new durable medical equipment, or DME, items.

Mod	Modifier Description, Definition, Explanation, and Tips
P1	**A normal healthy patient** **Definition:** The provider administers anesthesia to a normal healthy individual. **Explanation:** The anesthesia provider appends this modifier to an anesthesia code to show that the provider administers anesthesia to a normal healthy individual during any procedure. A normal healthy individual includes patients with no physiologic or psychiatric disorder and patients with a good level of exercise tolerance. It does not include very young and very old individuals. The medical record should justify the diagnosis that corresponds to the individual being normal and healthy. **Tips:** The anesthesia modifiers P1 to P6 identify the health condition of the patient in whom the provider is going to administer the anesthesia. The identification of the health condition helps the payer to determine the complexity of the anesthesia case. Many payers will reimburse more for anesthesia identified with modifiers P2 to P5 because the patient's case is likely more complex. Payers will not reimburse more for modifier P1 because the patient is normal and healthy or for P6 because the patient is brain dead. The provider uses this modifier only with anesthesia codes that range from 00100 to 01999. Coders will not append this modifier; only the anesthesia provider will append it.
P2	**A patient with mild systemic disease** **Definition:** The provider administers anesthesia to an individual with mild systemic disease. Patients with mild systemic disease have a well controlled disease of one body system. **Explanation:** The anesthesia provider appends this modifier to an anesthesia code to show that the provider administers anesthesia to an individual with mild systemic disease during any procedure. Patients with mild systemic disease have a well controlled disease of one body system, for example, controlled hypertension, controlled diabetes mellitus, mild obesity, or a smoking history with no symptoms of chronic obstructive pulmonary disease. Mild systemic disease does not affect the activities of daily living. The medical record should justify the diagnosis that corresponds to mild systemic disease. **Tips:** The anesthesia modifiers P1 to P6 identify the health condition of the patient in whom the provider is going to administer the anesthesia. The identification of the health condition helps the payer to determine the complexity of the anesthesia case. Many payers will reimburse more for anesthesia identified with modifiers P2 to P5 because the patient's case is likely more complex. Payers will not reimburse more for modifier P1 because the patient is normal and healthy or for P6 because the patient is brain dead. The provider uses this modifier only with anesthesia codes that range from 00100 to 01999. Coders will not append this modifier; only the anesthesia provider will append it.
P3	**A patient with severe systemic disease** **Definition:** The provider administers anesthesia to an individual with severe systemic disease. Patients with severe systemic disease have some limitation in activities and well controlled disease of more than one body system or one major body system. **Explanation:** The anesthesia provider appends this modifier to an anesthesia code to show that the provider administers anesthesia to an individual with severe systemic disease. Patients with severe systemic disease have some limitation in activities and well controlled disease of more than one body system or one major body system. For example, the category includes patients with stable angina, controlled congestive heart failure, poorly controlled hypertension, type 1 diabetes that has affected the vascular system, and moderate obesity. In severe systemic disease, there is no immediate danger of death. The medical record should justify the diagnosis that corresponds to severe systemic disease. **Tips:** The anesthesia modifiers P1 to P6 identify the health condition of the patient in whom the provider is going to administer the anesthesia. The identification of the health condition helps the payer to determine the complexity of the anesthesia case. Many payers will reimburse more for anesthesia identified with modifiers P2 to P5 because the patient's case is likely more complex. Payers will not reimburse more for modifier P1 because the patient is normal and healthy or for P6 because the patient is brain dead. The provider uses this modifier only with anesthesia codes that range from 00100 to 01999. Coders will not append this modifier; only the anesthesia provider will append it.

Mod	Modifier Description, Definition, Explanation, and Tips
P4	**A patient with severe systemic disease that is a constant threat to life** **Definition:** The provider administers anesthesia in an individual with severe systemic disease that is a constant threat to the life of the patient. **Explanation:** The anesthesia provider appends this modifier to an anesthesia code to show that the provider administers anesthesia to an individual with severe systemic disease that is a constant threat to life. Patients with severe systemic disease have a poorly controlled disease of more than one body system or one major body system. For example, the category includes patients with unstable angina, chronic renal failure, or symptomatic congestive heart failure. There is a possible risk and danger of death. The medical record should justify the diagnosis that corresponds to severe systemic disease that has a possible risk of death. **Tips:** The anesthesia modifiers P1 to P6 identify the health condition of the patient in whom the provider is going to administer the anesthesia. The identification of the health condition helps the payer to determine the complexity of the anesthesia case. Many payers will reimburse more for anesthesia identified with modifiers P2 to P5 because the patient's case is likely more complex. Payers will not reimburse more for modifier P1 because the patient is normal and healthy or for P6 because the patient is brain dead. The provider uses this modifier only with anesthesia codes that range from 00100 to 01999. Coders will not append this modifier; only the anesthesia provider will append it.
P5	**A moribund patient who is not expected to survive without the operation** **Definition:** The provider administers anesthesia to a terminally ill individual who will not survive without the operative procedure. **Explanation:** The provider administers anesthesia in a critically ill patient who will not survive without the operation. The medical record should justify the diagnosis that corresponds to a critically ill or injured patient who requires a life saving surgery. **Tips:** The anesthesia modifiers P1 to P6 identify the health condition of the patient in whom the provider is going to administer the anesthesia. The identification of the health condition helps the payer to determine the complexity of the anesthesia case. Many payers will reimburse more for anesthesia identified with modifiers P2 to P5 because the patient's case is likely more complex. Payers will not reimburse more for modifier P1 because the patient is normal and healthy or for P6 because the patient is brain dead. The provider uses this modifier only with anesthesia codes that range from 00100 to 01999. Coders will not append this modifier; only the anesthesia provider will append it.
P6	**A declared brain-dead patient whose organs are being removed for donor purposes** **Definition:** The provider administers anesthesia in a brain dead individual undergoing organ removal for donor purposes. **Explanation:** The anesthesia provider appends this modifier to an anesthesia code to show that the provider administers anesthesia to a brain dead individual undergoing organ removal for donor purposes. Brain death is the complete and irreversible cessation of brain function as determined by two doctors not associated with the transplant team. The medical record should justify the diagnosis that corresponds to a brain dead individual for organ donor purposes. **Tips:** The anesthesia modifiers P1 to P6 identify the health condition of the patient in whom the provider is going to administer the anesthesia. The identification of the health condition helps the payer to determine the complexity of the anesthesia case. Many payers will reimburse more for anesthesia identified with modifiers P2 to P5 because the patient's case is likely more complex. Payers will not reimburse more for modifier P1 because the patient is normal and healthy or for P6 because the patient is brain dead. The provider uses this modifier only with anesthesia codes that range from 00100 to 01999. Coders will not append this modifier; only the anesthesia provider will append it.

Mod	Modifier Description, Definition, Explanation, and Tips
PA	**Surgical or other invasive procedure on wrong body part** **Definition:** Append this modifier to indicate an adverse event when the provider performs a surgical or other invasive procedure on the wrong body part. **Explanation:** The provider appends modifier PA to surgical codes when he performs a surgical or other invasive procedure on the wrong body part due to an error. He appends this modifier so that the insurer including Medicare knows not to provide reimbursement. Not adhering to the Centers for Medicare and Medicaid Services, or CMS, guidelines of appending this modifier in situations where a provider performs a surgical or other invasive procedure on a body part that is not consistent with the correct documentation on the patient consent form may result in payment by the insurer and recoupment of the payment later on. Typically, the insurer considers all services the provider delivers in the operating room when an error occurs as related and considers them non covered as well. All other providers in the operating room when the error occurs, who bill individually for their services, are also not eligible for payment. Finally, all related services the patient receives during the same hospitalization in which the error occurs are usually not covered. **Tips:** Modifier PA notifies the insurer of the situation and ensures that the provider will not receive payment for the procedure done in error. Medicare also will not cover services related to the error. Using this modifier may increase malpractice risk. Use this modifier only with surgical codes.
PB	**Surgical or other invasive procedure on wrong patient** **Definition:** Append the PB modifier to indicate an adverse event when the provider performs a surgical or other invasive procedure on the wrong patient. **Explanation:** The provider appends modifier PB to codes when he performs a surgical or other invasive procedure on the wrong patient. He appends this modifier so that the insurer including Medicare knows not to provide reimbursement. Not adhering to the Centers for Medicare and Medicaid Services, or CMS, guidelines of appending this modifier in situations where a provider performs a surgical or other invasive procedure on the wrong patient may result in payment by the insurer and recoupment of the payment later on. Typically, the insurer considers all services the provider delivers in the operating room when an error occurs as related and considers them non covered as well. All other providers in the operating room when the error occurs, who bill individually for their services, are also not eligible for payment. Finally, all related services the patient receives during the same hospitalization in which the error occurs are usually not covered. **Tips:** Modifier PB notifies the insurer of the situation and ensures that the provider will not receive payment for the procedure done in error. Medicare also will not cover services related to the error. Using this modifier may increase malpractice risk.
PC	**Wrong surgery or other invasive procedure on patient** **Definition:** Append the PC modifier to indicate an adverse event when the provider performs the wrong surgery or other invasive procedure on a patient. **Explanation:** The provider appends modifier PC to codes when he performs the wrong surgery or other invasive procedure on a patient. He appends this modifier so that the insurer including Medicare knows not to provide reimbursement. Not adhering to the Centers for Medicare and Medicaid Services, or CMS, guidelines of appending this modifier in situations where a provider performs wrong surgery or other invasive procedure on patient may result in wrong payment by insurer and recoupment of the payment later on. Typically, the insurer considers all services the provider delivers in the operating room when an error occurs as related and considers them non covered as well. All other providers in the operating room when the error occurs, who bill individually for their services, are also not eligible for payment. Finally, all related services the patient receives during the same hospitalization in which the error occurs are usually not covered. **Tips:** Modifier PC will ensure that you will not receive reimbursement for the procedure done in error and Medicare also will not cover services related to the error. Using this modifier may increase malpractice risk.

Mod	Modifier Description, Definition, Explanation, and Tips
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** **Definition:** Modifier PD is a payment modifier that a provider uses with diagnostic or related non diagnostic items or services that a provider delivers in a wholly owned or operated entity to a patient who becomes an inpatient within three days. **Explanation:** Append this modifier with Healthcare Common Procedure Code System, or HCPCS codes that the provider and supplier use to report preadmission diagnostic and non diagnostic services that relate to the admission. Use this modifier to identify that the entity providing the service is wholly owned or operated by the hospital and the patient who receives the services becomes an inpatient within three days. An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. And, an entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity. **Tips:** If the entity is not wholly owned or operated by a hospital, do not append modifier PD. Medicare will pay for the professional component of codes with a technical professional split that a provider delivers within three calendar days. When practices append PD to a code that doesn't have both professional and technical components, Medicare will pay for the service based on the facility rate.
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** **Definition:** Append modifier PI to a code for positron emission tomography, PET or PET computed tomography, CT imaging studies that a provider performs to help plan the initial treatment strategy in patients with tumors, suspected to be cancerous by other diagnostic testing or proven to be cancerous through a biopsy. The provider uses the study to determine the location or extent of the tumor. **Explanation:** Modifier PI illustrates the use of imaging studies such as positron emission tomography, PET, or PET computed tomography, CT, in patients known or strongly suspected of having a cancerous tumor, an abnormal growth of tissue that rapidly multiples and spreads throughout the body destroying normal cells. Computed tomography is when the provider rotates an X-ray tube and detectors around a patient, which produces a tomogram, a computer generated cross sectional image, which providers use to diagnose, manage, and treat the disease. These studies enable the provider to plan an initial treatment strategy for patients with tumors that are proven on biopsy or suspected of being cancerous by other diagnostic tests. **Tips:** Append modifier PI when services are related to F 18 fluoro D glucose or FDG PET imaging study. Append modifier PI for procedure codes, such as 78608, Brain imaging, positron emission tomography or PET; metabolic evaluation, and the PET range of codes 78811 through 78816.
PL	**Progressive addition lenses** **Definition:** Append modifier PL to a code for a patient undergoing eye procedures for progressive additional lenses. **Explanation:** Modifier PL illustrates an eye procedure in a patient for the fitting of progressive additional lenses. **Tips:** HCPCS Level II codes represent implantable materials used in the treatment of eye and ear disorders. These codes also report the supplies of visual aids such as contact lenses and glasses.
PM	**Post mortem** **Definition:** Append modifier PM to a code to identify post mortem visits to a patient. **Explanation:** Modifier PM identifies visits that occur after the death of a patient and on the same day as the patient's death, from visits occurring before death. Providers append the PM modifier for post mortem visits, on the date of death, regardless of the patient's level of care or site of service. The date of death is the date of death reported on the death certificate. Hospice providers are to report hospice visits that occur before death separately from those which occur after death. **Tips:** Do not report post mortem visits occurring on a date subsequent to the date of death, due to system limitations with reporting services after the date of the death. Report modifier PM when billing post mortem visits provided on the date of death beginning with services on or after April 1, 2014.

Mod	Modifier Description, Definition, Explanation, and Tips
PN	**Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital** **Definition:** Modifier PN represents the technical component of non-excepted items and services. **Explanation:** With this modifier, hospitals are paid under the MPFS for non-excepted items and services, which are billed on the institutional claim and must be billed with a new claim line modifier PN to indicate that an item or service is a non-excepted item or service. The payment rate for these services will generally be 50 percent of the OPPS rate with some exceptions. Packaging, and certain other OPPS policies, will continue to apply to such services. Check the CMS website for specific reimbursement information related to services with modifier PN appended, as certain non-excepted services may be paid under MPFS. Do not append modifier PN to excepted items and services – Certain off-campus provider-based departments (PBDs) are permitted to continue to bill Medicare for excepted items and services under the OPPS. Excepted items and services are: All items and services furnished in a dedicated emergency department. Items and services that were furnished and billed by an off-campus PBD prior to November 2, 2015. Items and services furnished in a hospital department within 250 yards of a remote location of the hospital.
PO	**Excepted service provided at an off-campus, outpatient, provider-based department of a hospital** **Definition:** Append the PO modifier to indicate a service, procedure, or surgery that takes place at a provider based hospital outpatient department, off campus. **Explanation:** A hospital facility appends modifier PO to a code for each service, procedure, or surgery that takes place at an off campus location in a provider based outpatient department. Off campus means a location physically separate from the immediate area of the hospital facility and or in a building located more than 250 yards away from the main hospital buildings. This is an informational modifier for data collection purposes. **Tips:** Individual providers should not append modifier PO and instead should use the appropriate place of service code to indicate outpatient services furnished in an on campus, remote, or satellite location of a hospital or in an off campus, provider based hospital setting.
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** **Definition:** A provider appends modifier PS to a positron emission tomography, or PET, or computed tomography, or CT scan to determine a subsequent treatment strategy of cancerous tumors when the provider determines he needs the PET study to determine a subsequent antitumor strategy for the patient. **Explanation:** Modifier PS illustrates the use of imaging studies such as positron emission tomography, PET, or computed tomography, CT, in patients having a cancerous tumor, or an abnormal growth of tissue that rapidly multiplies and spreads throughout the body destroying normal cells. A positron emission tomography, or PET scan is a nuclear medicine imaging technique, which produces a three dimensional image of functional processes in the body; the system detects pairs of gamma rays emitted indirectly by a positron emitting radionuclide, or tracer, which is introduced into the body on a biologically active molecule, or glucose. A computed tomography, or CT scan is when the provider rotates an X-ray tube and detectors around a patient, which produces a tomogram, a computer generated cross sectional image, which providers use to diagnose, manage, and treat the disease. These studies enable the provider to determine a subsequent treatment strategy for patients with cancerous tumors. **Tips:** Append modifier PS to all procedure codes that the provider bills with a cancer diagnosis codes such as, 78608, Brain imaging, positron emission tomography or PET; metabolic evaluation, and code range 78811 to 78816. While submitting claim for the professional component only, append modifier 26 first, and then append modifier PS. While submitting claim for the technical component only, append modifier TC first, and then append modifier PS.
PT	**Colorectal cancer screening test; converted to diagnostic test or other procedure** **Definition:** Append this modifier when a colorectal cancer screening test converts to a diagnostic or therapeutic procedure. **Explanation:** Append modifier PT when the provider performs screening colonoscopy, flexible sigmoidoscopy, or barium enema and finds and or removes a lesion or performs a biopsy during the same encounter. **Tips:** Modifier PT waives the deductible for services furnished in connection with or in relation to a colorectal cancer screening test 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 and that became diagnostic or therapeutic. Codes associated with this modifier fall in the range of 10021-69990, Surgery.

Mod	Modifier Description, Definition, Explanation, and Tips
Q0	**Investigational clinical service provided in a clinical research study that is in an approved clinical research study** **Definition:** Append modifier Q0 for a service which the provider performs for an approved investigative clinical research study. **Explanation:** Approved investigational clinical services consist of services that the provider investigates as an objective within the study. Not all investigational clinical services are approved. Investigational clinical services may include services that are approved, unapproved, or otherwise covered or not covered under Medicare. **Tips:** Append modifiers Q0 and Q1 on outpatient provider claims for services provided in Medicare qualified clinical trials studies. These include trials that fall under the 2007 Medicare Clinical Trial Policy, trials that a specific National Coverage Determination or NCD, and investigational device exemption or IDE trials required.
Q1	**Routine clinical service provided in a clinical research study that is in an approved clinical research study** **Definition:** Append modifier Q1 for a routine clinical service that the provider performs for a patient enrolled in an approved clinical research study. **Explanation:** The CMS defines routine clinical services as those items and services that Medicare typically covers for beneficiaries outside of the clinical research study that the provider uses for direct patient management within the study and that 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. **Tips:** Append modifiers Q0 and Q1 on outpatient provider claims for services provided in Medicare qualified clinical trials studies. These include trials that fall under the 2007 Medicare Clinical Trial Policy, trials that a specific National Coverage Determination or NCD, and investigational device exemption or IDE trials requires.
Q2	**Demonstration procedure/service** **Definition:** Append modifier Q2 to services billed in conjunction with a demonstration procedure or service. **Explanation:** CMS conducts and sponsors demonstration projects to test and measure the effect of potential program changes. The demonstrations study the likely impact of new methods of service delivery, coverage of new types of service, and new payment approaches on beneficiaries, providers, health plans, states, and the Medicare Trust Funds. Append modifier Q2 when the services involve demonstration of a procedure/service to allow accurate identification and documentation of payment for Medicare beneficiaries enrolled in the demonstration.
Q3	**Live kidney donor surgery and related services** **Definition:** Append modifier Q3 when the provider performs services related to care for a live kidney donor. **Explanation:** The provider appends modifier Q3 for care for a live kidney donor to receive 100 percent reimbursement of the allowed charge. Live kidney donor services include those services which the provider performs during the preoperative, intraoperative, and postoperative periods. The provider bills these services to the carrier under the name and health insurance claim number of the kidney recipient. **Tips:** Medicare part B reimburses for services reported with modifier Q3 if the provider bills the transplant surgery codes 50320, Donor nephrectomy including cold preservation; open, from living donor or 50547, Laparoscopy, surgical; donor nephrectomy including cold preservation, from living donor.
Q4	**Service for ordering/referring physician qualifies as a service exemption** **Definition:** Append this modifier when a provider orders a service from or refers a Medicare beneficiary to another service provider with whom the original provider has a financial relationship if the service provided qualifies as a service related exemption. **Explanation:** Service related exemptions permit a provider to refer a Medicare beneficiary to a service entity with whom the referring provider has a financial relationship. Append modifier Q4 to the code for the service when an exemption applies. This modifier is for informational purposes only and does not affect the reimbursement. **Tips:** Unless an exception applies, if a physician or a member of a physician's immediate family has a financial relationship with a healthcare entity, the physician may not make referrals to that entity for the furnishing of designated health services, or DHS under the Medicare program. The following services are DHS: clinical laboratory services; physical therapy services; occupational therapy services; radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. Individual payers may have policies that specify which nonphysicians you may use this modifier for. Check the payer's individual policy to be sure.

Mod	Modifier Description, Definition, Explanation, and Tips
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** **Definition:** Append modifier Q5 when a substitute provider (physician or physical therapist) evaluates a patient under a reciprocal billing arrangement in a rural area or an area with a shortage of healthcare professionals or medical services. **Explanation:** Modifier Q5 denotes when another provider examines or treats a patient due to absence of the regular provider and based on a prior agreement to cover for one another, when the care takes place in a rural or underserved area. The alternate provider should sign any reports documenting the care he provided. **Tips:** The patient's regular physician may submit the claim, and, if assignment is accepted, receive the Part B payment, for covered visit services, including emergency visits and related services, which the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis under the following conditions: The regular physician must not be available to provide the visit services; and The Medicare patient needs to arrange or seek to receive the visit services from the regular physician; and This modifier is to be used by providers who render services to patients in a rural area, an area where there is a shortage of healthcare professionals, or an otherwise underserved area. The substitute physician may not provide the visit services to Medicare patients over a continuous period of longer than 60 days subject with an exception for the provider being on active military duty; and The regular physician must identify the services as substitute physician services by entering HCPCS code Q5 modifier, service furnished by a substitute physician under a reciprocal billing arrangement, after the procedure code. The regular physician must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN or NPI when required, and make this record available to the carrier upon request. If the only substitution services a physician performs in connection with an operation are postoperative services furnished during the period covered by the global fee, these services need not be identified on the claim as substitution services. A physician may have reciprocal arrangements with more than one physician. The arrangements need not be in writing. The regular physician is not entitled to bill and receive direct payment for substitute provider services furnished after the expiration of 60 days of the period. The substitute physician must bill for these services in his or her own name. The regular physician may, however, bill and receive payment for the services that the substitute physician provides on his or her behalf during the 60 day the period. The provider should append modifier Q5 with the supporting documentation providing the reason for the service.
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** **Definition:** Append this modifier when a locum tenens, or substitute, provider (physician or physical therapist) performs the services under a fee-for-time compensation agreement, in a rural area or an area with a shortage of healthcare professionals or medical services. **Explanation:** Append modifier Q6 when a locum tenens, or substitute, provider performs healthcare services in the absence of the original provider. Criteria for this modifier include that the regular physician is unavailable to provide the visit services; the Medicare beneficiary has arranged or seeks to receive the visit services from the regular physician; the regular physician pays the locum tenens for his or her services on a per diem or similar fee for time basis; the substitute physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days subject to some exceptions; the provider renders services to patients in a rural area, an area where there is a shortage of healthcare professionals, or an otherwise underserved area.; and the regular physician identifies the services as substitute physician services meeting the requirements of this section by entering HCPCS code modifier Q6. **Tips:** The locum tenens provider provides a service when the original provider is not present to provide due to any illness, pregnancy, vacation or continuation of medical education. If a provider leaves a medical group and the group hires a locum tenens physician, the medical group must keep on file a record of each service which the substitute provider assumes and also takes a note of the substitute provider's PIN or NPI. Also, the provider identification number PIN or NPI of the provider who has left the medical group is written on the claim to indicate who the locum tenens provider is substituting for. This modifier is to be used by providers who render services to patients in a rural area, an area where there is a shortage of healthcare professionals, or an otherwise underserved area. This modifier has no effect on payment.

Mod	Modifier Description, Definition, Explanation, and Tips
Q7	**One class A finding** **Definition:** Append this modifier for foot care that involves at least one class A findings. The provider uses class findings to determine the level of foot care. Medicare does not cover routine foot care unless the patient is suffering from systemic conditions which lead to decreased sensation over the area of foot and leg or when the foot care is essential. **Explanation:** Append modifier Q7 when the provider identifies one class A finding. The provider uses class findings to determine the level of foot care. Class A findings include nontraumatic amputation of foot or integral skeletal portion thereof. Medicare covers the service when the provider renders foot care and identifies one class A finding. Medicare does not cover routine foot care unless the patient is suffering from systemic conditions which lead to decreased sensation over the area of foot and leg or when the foot care is essential. Services ordinarily considered routine might also be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds, and infections or if the patient has peripheral neuropathy, i.e., decreased sensation in the extremities that might result in injury if the patient tries to take care of his or her nails. Routine foot care involves excision of corns or calluses, maintenance of cleanliness of foot in bedridden patient, and trimming or debridement of nails. **Tips:** Append modifier Q9, One class B and two class C findings, when the provider identifies one class B and two class C findings. Append modifier Q8, Two class B findings, when the provider identifies two class B findings. Modifiers Q7, Q8, and Q9 should usually be used with HCPCS code G0127, Trimming of dystrophic nails, any number, or CPT® codes 11055 to 11057, Paring or cutting of benign hyperkeratotic lesion, e.g., corn or callus, depending on number of lesions; 11719, Trimming of nondystrophic nails, any number; and when appropriate, 11720, Debridement of nails by any methods; 1 to 5; or 11721, Debridement of nails by any methods; 6 or more.
Q8	**Two class B findings** **Definition:** Append this modifier for foot care required because of two class B findings. The provider uses class findings to determine the level of foot care. Medicare does not cover routine foot care unless the patient has systemic conditions which lead to decreased sensation over the area of foot and leg or when the foot care is essential. **Explanation:** Append modifier Q8 when the provider identifies two class B findings. The provider uses class findings to determine the level of foot care. Class B findings include absent posterior tibial pulse, absent dorsalis pedis pulse, advanced trophic changes which include any three of the following conditions, such as increased or decreased hair growth; nail thickening; or changes in color, texture, or reddening of the skin. Medicare does not cover routine foot care unless the patient has systemic conditions which lead to decreased sensation over the area of foot and leg or when the foot care is essential. Services ordinarily considered routine might also be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds, and infections or if the patient has peripheral neuropathy, i.e., decreased sensation in the extremities that might result in injury if the patient tries to take care of his or her nails. Routine foot care involves excision of corns or calluses, maintenance of cleanliness of foot in bedridden patient, and trimming or debridement of nails. **Tips:** Append modifier Q9, One class B and two class C findings, when the provider identifies one class B and two class C findings. Append modifier Q7, One class A finding, when the provider identifies one class A finding. Modifiers Q7, Q8, and Q9 should usually be used with HCPCS code G0127, Trimming of dystrophic nails, any number, or CPT® codes 11055 to 11057, Paring or cutting of benign hyperkeratotic lesion, e.g., corn or callus, depending on number of lesions; 11719, Trimming of nondystrophic nails, any number; and when appropriate, 11720, Debridement of nails by any methods; 1 to 5; or 11721, Debridement of nails by any methods; 6 or more.

Mod	Modifier Description, Definition, Explanation, and Tips
Q9	**One class B and two class C findings** **Definition:** Append this modifier for routine foot care services for one class B finding and two class C findings. The provider uses class findings to determine the level of foot care. Medicare does not cover routine foot care unless the patient has systemic conditions which lead to decreased sensation over the area of foot and leg or when the foot care is essential. **Explanation:** Append modifier Q9 when the provider identifies one class B and two class C findings. The provider uses class findings to determine the level of foot care. Class B findings include absent posterior tibial pulse, absent dorsalis pedis pulse, advanced trophic changes which include any three of the following conditions, such as increased or decreased hair growth; nail thickening; or changes in color, texture, or reddening of the skin. Class C findings include claudication, burning, coldness of the feet, edema, tingling or abnormal spontaneous sensations in the feet. Medicare does not cover routine foot care unless the patient has systemic conditions which lead to decreased sensation over the area of foot and leg or when the foot care is essential. Services ordinarily considered routine might also be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds, and infections or if the patient has peripheral neuropathy, i.e., decreased sensation in the extremities that might result in injury if the patient tries to take care of his or her nails. Routine foot care involves excision of corns or calluses, maintenance of cleanliness of foot in bedridden patient, and trimming or debridement of nails. **Tips:** Append modifier Q8, Two class B findings, when the provider identifies two class B findings. Append modifier Q7, One class A finding, when the provider identifies one class A finding. Modifiers Q7, Q8, and Q9 should usually be used with HCPCS code G0127, Trimming of dystrophic nails, any number, or CPT® codes 11055 to 11057, Paring or cutting of benign hyperkeratotic lesion, e.g., corn or callus, depending on number of lesions; 11719, Trimming of nondystrophic nails, any number; and when appropriate, 11720, Debridement of nails by any methods; 1 to 5; or 11721, Debridement of nails by any methods; 6 or more.
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)** **Definition:** Add modifier QA to a code when a patient at rest requires different amounts of stationary oxygen during the daytime and nighttime but the average of the two amounts is less than 1 L per minute (LPM). **Explanation:** Use this modifier when the provider prescribes two different amounts of stationary oxygen for daytime and nighttime use for a patient at rest but the averaged amounts equal less than 1 L per minute. The prescribed oxygen amount depends upon the severity of disease. In severe conditions like chronic obstructive pulmonary disease (COPD) or chronic respiratory failure (CRF) the lungs fail to provide sufficient oxygen to the body tissues. Sufficient oxygen is essential for all normal physiological functions. **Tips:** See QB, QE, QF, QG, QH and QR for other oxygen-related modifiers.
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** **Definition:** Append modifier QB when a provider prescribes different amounts of stationary oxygen for daytime and nighttime use for a patient at rest and the average of the two amounts is greater than 4 L per minute (LPM), when the patient also has portable oxygen prescribed. **Explanation:** Use this modifier when a patient at rest receives different amounts of provider-prescribed stationary oxygen for daytime and nighttime use and the two amounts average out to greater than 4 L per minute, and the patient also has portable oxygen. The prescribed oxygen amount depends upon the severity of disease. In severe conditions like chronic obstructive pulmonary disease (COPD) or chronic respiratory failure (CRF) the lungs fail to provide sufficient oxygen to the body tissues. Sufficient oxygen is essential for all normal physiological functions. **Tips:** Proper use of QB is important because Medicare increases monthly payment for oxygen when the patient has a prescription for portable oxygen in addition to stationary oxygen. See QA, QE, QF, QG, QH and QR for other oxygen-related modifiers.
QC	**Single channel monitoring** **Definition:** Append this modifier for single channel monitoring. Report this modifier for informational purposes only; it does not affect payment. **Explanation:** Append modifier QC when the provider performs single channel monitoring. Report this modifier for informational purposes only; it does not affect payment. Providers routinely monitor patients in the ICU using single-channel electrocardiogram, or ECG, monitoring. **Tips:** Individual payers may have policies that specify which nonphysicians you may use this modifier for. Check the payer's individual policy to be sure.

Mod	Modifier Description, Definition, Explanation, and Tips
QD	**Recording and storage in solid state memory by a digital recorder** **Definition:** Append this modifier for recording and storage by a digital recorder in solid state memory. Report this modifier for informational purposes only; it does not affect payment. **Explanation:** Append modifier QD when the provider records and stores the voice data by a digital recorder in a solid state memory. Report this modifier for informational purposes only; it does not affect payment. **Tips:** Individual payers may have policies that specify which nonphysicians you may use this modifier for. Check the payer's individual policy to be sure.
QE	**Prescribed amount of stationary oxygen while at rest is less than 1 liter per minute (LPM)** **Definition:** Append this modifier when a provider prescribes oxygen at less than 1 L per minute (LPM) to a patient. This modifier may be appended only to HCPCS codes for stationary oxygen systems. **Explanation:** Append modifier QE when the supplier prescribes oxygen at less than 1 LPM using a stationary oxygen system for a patient. You should not append this modifier with codes for portable systems or oxygen contents. **Tips:** Append modifier QE with stationary gaseous E0424, Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flow meter, humidifier, nebulizer, cannula or mask, and tubing or liquid E0439, Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing systems or with an oxygen concentrator E1390, Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate and E1391, Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each. Fee schedule payments for stationary oxygen system rentals are all inclusive and represent a monthly allowance per beneficiary. Accordingly, a supplier must bill on a monthly basis for stationary oxygen equipment and contents furnished during a rental month. The monthly payment of stationary oxygen decreases by 50 percent if the home health agency supplies stationary oxygen. The suppliers bill this service by appending modifier QE. See QA, QB, QF, QG, QH and QR for other oxygen-related modifiers.
QF	**Prescribed amount of stationary oxygen while at rest exceeds 4 liters per minute (LPM) and portable oxygen is prescribed** **Definition:** Append modifier QF to a code for a patient who is oxygen dependent at rest and receiving more than 4 L of oxygen per minute via a stationary oxygen supply, and who has a provider-prescribed portable oxygen device. **Explanation:** Modifier QF illustrates the quantity of oxygen prescribed, more than 4 L per minute (LPM) to the lungs via a stationary oxygen supply for a patient at rest, as well as prescription of a portable oxygen device. The prescribed oxygen amount depends upon the severity of disease. In severe conditions like chronic obstructive pulmonary disease (COPD) or chronic respiratory failure (CRF) the lungs fail to provide sufficient oxygen to the body tissues. Sufficient oxygen is essential for all normal physiological functions. **Tips:** When the oxygen supply is greater than 4 LPM without use of portable oxygen, use modifier QG (Prescribed Amount Of Stationary Oxygen While At Rest Is Greater Than 4 Liters Per Minute [LPM]). Proper use of QF is important because Medicare increases monthly payment for oxygen when the patient has a prescription for portable oxygen in addition to stationary oxygen. See QA, QB, QE, QG, QH and QR for other oxygen-related modifiers.
QG	**Prescribed amount of stationary oxygen while at rest is greater than 4 liters per minute (LPM)** **Definition:** Append modifier QG to a code for a patient who is oxygen dependent at rest, and the provider prescribes oxygen via stationary supply at more than 4 L per minute. **Explanation:** Modifier QG illustrates the quantity of oxygen prescribed via a stationary supply at more than 4 L per minute (LPM) for a patient at rest. The prescribed oxygen amount depends upon the severity of disease. In severe conditions like chronic obstructive pulmonary disease (COPD) or chronic respiratory failure (CRF), the lungs fail to provide sufficient oxygen to the body tissues. Sufficient oxygen is essential for all normal physiological functions. **Tips:** When the oxygen supply is greater than 4 LPM using a stationary supply, and the patient also has use of a portable oxygen supply, use modifier QG. Proper use of QG is important because Medicare increases monthly payment for oxygen when the patient has a prescription for portable oxygen in addition to stationary oxygen at greater than 4 LPM. See QA, QB, QE, QF, QH and QR for other oxygen-related modifiers.

Mod	Modifier Description, Definition, Explanation, and Tips
QH	**Oxygen conserving device is being used with an oxygen delivery system** **Definition:** Append modifier QH to indicate the patient uses a device that controls oxygen flow from an oxygen cylinder based on the rate of inhalation or by delivering pulses of oxygen at fixed volumes per breath. **Explanation:** Modifier QH represents use of an oxygen conserving device with an oxygen delivery system. Patients who are unable to breathe properly due to severe lung disease need supplemental oxygen. The oxygen conserving device, OCD, on a tank or portable oxygen concentrator makes the oxygen supply last longer. It makes oxygen therapy more efficient, more portable, and more cost effective. **Tips:** Medicare requires home health agencies and other suppliers to use modifier QH to indicate the use of an oxygen conserving device. See QE to QH for the range of oxygen related modifiers.
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)** **Definition:** Append modifier QJ to a code when the provider supplies the service or item to a patient in jail or custody, subject to the regulations at 42 CFR 411.4 (b). The regulations state Medicare may provide payment if the patient in custody has to repay the cost of the service or item provided to him. **Explanation:** Append modifier QJ only if a medical service or item goes to a prisoner or patient in custody whose state or local law requires him to pay for his own medical care, meeting the conditions of 42 CFR411.4b. Typically the state or local government is responsible for covering the costs of patients in custody, but those regulations say that Medicare may pay for services provided to a person in custody if the situation meets two conditions. The first condition is that state or local law requires the person to repay the cost of medical service she received while in custody. The second condition is that the state or local government bills individuals who received medical care, whether under Medicare or not, and then the government follows the same debt collection practices it uses for other debts. **Tips:** You cannot use modifier QJ with service codes when the patient is not in jail or custody. It is incorrect to use modifier QJ if the patient is in jail but state or local government pays the medical bills. If Medicare denies a modifier QJ claim, you may appeal either by showing that the claim meets the conditions of 42 CFR 411.4b or by showing that the patient was not in custody under authority of penal statute.
QK	**Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals** **Definition:** An anesthesiologist provides medical direction for two to four procedures that overlap each other. **Explanation:** When a physician performs medical direction of two to four concurrent procedures with anesthesia services by qualified individuals, the physician appends modifier QK. Examples of qualified individuals include certified registered nurse anesthetists (CRNAs), anesthesiologist assistants (AAs), interns, and residents. Concurrent means that there is some degree of overlap in the procedures. Depending on payer rules, one minute of overlap may be enough for procedures to be considered concurrent. **Tips:** Check payer rules regarding what qualifies as medical direction.
QL	**Patient pronounced dead after ambulance called** **Definition:** Append modifier QL to an ambulance code when an ambulance arrives and the patient has died on scene. **Explanation:** Modifier QL applies to those ambulance services in which the ambulance reaches the site where the patient is, such as the accident site or home, and a qualified provider declares the patient legally dead before transport in the ambulance. **Tips:** If a provider declares a patient is dead after ambulance dispatch but before ambulance transport, use modifier QL to ensure proper payment. Medicare payment will reflect the basic life support base rate but not mileage or the adjustment for rural services. For payers other than Medicare, check their specific policies.
QM	**Ambulance service provided under arrangement by a provider of services** **Definition:** Append QM modifier to ambulance codes for ambulance services provided under arrangement between the provider and an ambulance company. **Explanation:** When the provider has an arrangement with an ambulance company for ambulance services, then provider appends modifier QM with such ambulance services. **Tips:** If the requesting provider and ambulance service provider are one and the same, append modifier QN, Ambulance service furnished directly by a provider of services. All HCPCS ambulance codes must have a QM or QN modifier.

Mod	Modifier Description, Definition, Explanation, and Tips
QN	**Ambulance service furnished directly by a provider of services** **Definition:** Append modifier QN to codes for ambulance services supplied directly by the provider. **Explanation:** Use modifier QN to identify ambulance services the provider supplies directly rather than under financial arrangement with outside ambulance service providers. **Tips:** When the provider has an arrangement with an ambulance company for ambulance services, then provider appends modifier QM, Ambulance service provided under arrangement by a provider of services. When ambulance services are provided by another service provider, it may affect reimbursement for these services from outside vendor. All HCPCS ambulance codes must have a QN or QM modifier.
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.** **Definition:** Append modifier QP to laboratory service codes when the clinician orders the test as a single test, whether as an individual test or as a panel. **Explanation:** Laboratory providers append modifier QP to those single laboratory CPT® codes for individual tests or panel tests. For example, if the lab performs many tests like total serum cholesterol, triglycerides, and high density lipid profile, the lab may report them with the single laboratory code 80061, Lipid panel, with modifier QP. When you append this modifier, you're letting the payer know that you have documentation available that the clinician ordered an individual test or a panel represented by a single CPT® code. **Tips:** Modifier QP is an informational modifier that does not affect payment. Note: Codes 80002-80019, G0058, G0059, and G0060 are deleted CPT® and HCPCS codes, but are still included in this official descriptor from CMS.
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)** **Definition:** Add modifier QR to a code when a patient at rest requires different amounts of stationary oxygen during the daytime and nighttime and the average of the two amounts is greater than 4 L per minute (LPM). **Explanation:** Use this modifier when the provider prescribes two different amounts of stationary oxygen for daytime and nighttime use for a patient at rest and the two amounts average greater than 4 L per minute. The prescribed oxygen amount depends upon the severity of disease. In severe conditions like chronic obstructive pulmonary disease (COPD) or chronic respiratory failure (CRF) the lungs fail to provide sufficient oxygen to the body tissues. Sufficient oxygen is essential for all normal physiological functions. **Tips:** When the daytime and nighttime oxygen supply averages greater than 4 LPM and the patient also has a prescribed portable oxygen supply, use modifier QB. See QA, QB, QE, QF, QG, and QH for other oxygen-related modifiers.
QS	**Monitored anesthesia care service** **Definition:** Append modifier QS to an anesthesia code when the anesthesia provider's services meet the definition of monitored anesthesia care, or MAC. MAC refers a combination of a local anesthetic with sedation generally administered by a provider who is qualified to provide general anesthesia. **Explanation:** Modifier QS indicates that the anesthesia provider, who may be an anesthesiologist or other qualified individual such as a Certified Registered Nurse Anesthetist, CRNA, or Anesthesiologist Assistant, AA, performs monitored anesthesia care. MAC involves monitoring the patient's vital signs while in the operating room, examination prior to anesthesia, the prescription for anesthesia care, and postoperative care. **Tips:** This modifier does not impact reimbursement; it is informational only. Use this modifier in addition to P modifiers for anesthesia codes. If anesthesia provider provides monitored anesthesia care for deep complex, complicated, or markedly invasive surgical procedure, use modifier G8. If anesthesia provider provides monitored anesthesia care for a patient who has history of severe cardiopulmonary condition, use modifier G9. Some payers may pay more for this modifier as long as reasons for providing MAC are medically necessary and documented in the record.
QT	**Recording and storage on tape by an analog tape recorder** **Definition:** Append modifier QT to any CPT® or HCPCS code when a recording is made on analog tape while performing any procedure. **Explanation:** Append this modifier when the provider records any procedure or part of a procedure on analog tape. This modifier does not impact reimbursement, it is purely informational only. **Tips:** You can use this modifier at the last modifier position after all other important modifiers.

Mod	Modifier Description, Definition, Explanation, and Tips
QW	**CLIA waived test** **Definition:** Append modifier QW to a laboratory test which has been waived from Clinical Laboratory Improvement Amendments requirements. It is compulsory to have CLIA number for such Centers. **Explanation:** Append this modifier to codes for individual laboratory tests that have been waived by the FDA from CLIA requirements. All medical laboratories, including physician office laboratories, must have CLIA certification in order to receive payments from Medicare and Medicaid. The FDA waives some individual tests from CLIA requirements, and CMS publishes a list of these CLIA waived tests quarterly. Lists of waived tests may be obtained from the CMS CLIA web page and clicking on Categorization of Tests in the menu and downloading Tests Granted Waived Status Under CLIA. Providers may use this list to determine if a particular test product can be appropriately performed by a laboratory with a CLIA waiver and is eligible to be billed using the QW modifier.
QX	**CRNA service: with medical direction by a physician** **Definition:** A certified registered nurse anesthetist (CRNA) performs a service under the medical direction of a physician. **Explanation:** When a certified registered nurse anesthetist (CRNA) performs an anesthesia service under the medical direction of a physician, the CRNA appends modifier QX on the claim. **Tips:** The anesthesiologist providing medical direction should use a different modifier, such as modifier QY. If a CRNA performs anesthesia services without medical direction, the CRNA should use modifier QZ. Check payer rules regarding what qualifies as medical direction.
QY	**Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist** **Definition:** An anesthesiologist provides medical direction of one certified registered nurse anesthetist (CRNA). **Explanation:** When an anesthesiologist provides medical direction of one certified registered nurse anesthetist (CRNA) performing an anesthesia service, the anesthesiologist appends modifier QY on the claim. **Tips:** The CRNA performing the procedure should use modifier QX. See modifier QK for medical direction of two to four concurrent anesthesia procedures. Check payer rules regarding what qualifies as medical direction.
QZ	**CRNA service: without medical direction by a physician** **Definition:** A certified registered nurse anesthetist (CRNA) performs a service that a physician does not provide medical direction for. **Explanation:** When a certified registered nurse anesthetist (CRNA) performs an anesthesia service without the medical direction of a physician, the CRNA appends modifier QZ on the claim. **Tips:** If a CRNA performs anesthesia services with medical direction, use modifier QX. Check payer policy for rules regarding what qualifies as medical direction.
RA	**Replacement of a DME, orthotic or prosthetic item** **Definition:** Append the modifier RA when the provider replaces the durable medical equipment, prosthetics, or orthotics, and supplies, or DMEPOS, when the beneficiary loses the item or damages it in such a way that it can't be repaired. **Explanation:** Append this modifier to the claim for the replacement of DMEPOS when the supplier furnishes the beneficiary with a new item, identical to the original item, to replace a lost, stolen, or irreparably damaged item. Irreparable damage refers to the wear and tear of the equipment due to an accident, disaster, day to day use, or other event. The medical documentation must include the details related to the replacement of the item. Append the RA modifier on all DMEPOS claims where an item replaces the same item which has been lost, stolen, or irreparably damaged prior to the equipment's reasonable useful lifetime and also for billing replacement claims when the DMEPOS item has met its reasonable useful lifetime. CMS encourages suppliers to enter the abbreviation RUL which indicates reasonable useful lifetime and the date the beneficiary received the original equipment that is being replaced when billing for an item that has met its reasonable useful lifetime use. **Tips:** If the supplier replaces only a part of the item to repair it, use modifier RB, Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair.

Mod	Modifier Description, Definition, Explanation, and Tips
RB	**Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair** **Definition:** Append the modifier RB when the provider replaces a part of the durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS, to repair the item. **Explanation:** Append this modifier to the claim for the replacement of a part of the DMEPOS, so as to repair the damage. The supplier furnishes the beneficiary with a new replacement part for a damaged or worn out part of the item. The medical documentation must include the details related to the replacement of the part of the item, including the amount of time the repair takes, the HCPCS code for the base equipment, that the patient owns the equipment, and the date the patient acquired the equipment. This modifier applies only to items that the beneficiary owns. If the beneficiary rents the DMEPOS item, the rental amount includes the cost of repair and maintenance. **Tips:** If the provider replaces the item completely, use modifier RA, Replacement of a DME, orthotic or prosthetic item.
RC	**Right coronary artery** **Definition:** Append modifier RC to a code for procedures on the right coronary artery. **Explanation:** Append this modifier to codes when the provider performs a procedure on the right coronary artery. The right coronary artery supplies blood to the right atrium and ventricle of the heart, i.e., the upper and the lower chamber of the heart respectively. **Tips:** The various types of procedures on the right coronary artery include angioplasty, atherectomy, stent placement, or grafting. If the provider performs a procedure on the left circumflex, append modifier LC, Left circumflex coronary artery. If the provider performs a procedure on the left anterior descending artery, use modifier LD, Left anterior descending coronary artery. If the provider targets the main coronary artery, use modifier LM, Left main coronary artery. If the provider performs a procedure on ramus intermedius coronary artery, use modifier RI, Ramus intermedius coronary artery.
RD	**Drug provided to beneficiary, but not administered "incident-to"** **Definition:** Append modifier RD to a claim for a drug that the provider supplies to the beneficiary and the beneficiary may administer the drug on his own. **Explanation:** Report this modifier when the provider supplies a drug to the beneficiary which he may administer on his own. The phrase incident to refers to when the provider administers or supplies a drug as part of his services, such as those necessary to accomplish a primary procedure.
RE	**Furnished in full compliance with FDA-mandated risk evaluation and mitigation strategy (REMS)** **Definition:** Append modifier RE to report extended release or long acting opioid drugs that the provider supplies in compliance with the Food and Drug Administration, or FDA, risk evaluation and mitigation strategy, or REMS. **Explanation:** Append this modifier to the code for an extended release, ER, or long acting, LA, opioid drug, which the provider supplies in compliance with the FDA's risk evaluation and mitigation strategy. ER, LA opioids are highly potent FDA approved drugs, such as morphine sulfate, fentanyl, oxycodone, and hydrocodone, used to treat moderate to severe persistent pain for serious and chronic conditions. The misuse and abuse of these drugs have resulted in a serious public health crisis of addiction, overdose, and death. The REMS is part of a multiagency federal effort to address the growing problem of prescription drug abuse and misuse. The REMS introduces new safety measures to reduce risks and improve safe use of ER, LA opioids while continuing to provide access to these medications for patients in pain.
RI	**Ramus intermedius coronary artery** **Definition:** Append modifier RI to the codes for a procedure on the ramus intermedius coronary artery. **Explanation:** Append this modifier to the code when the provider performs a procedure on the ramus intermedius coronary artery. The ramus intermedius coronary artery branches off the left coronary artery, one of the major arteries that supplies blood to the left atrium and ventricle of the heart, i.e., the upper and the lower chambers of the heart respectively. **Tips:** The various types of procedures on the coronary artery include angioplasty, atherectomy, stent placement, or grafting. If the provider performs a procedure on the left circumflex, append modifier LC, Left circumflex coronary artery. If the provider performs a procedure on the left anterior descending artery, use modifier LD, Left anterior descending coronary artery. If the provider targets the main coronary artery, use modifier LM, Left main coronary artery. If the provider performs a procedure on right coronary artery, use modifier RC, Right coronary artery.

Mod	Modifier Description, Definition, Explanation, and Tips
RR	**Rental (use the 'RR' modifier when DME is to be rented)** **Definition:** A provider appends modifier RR to identify the use of rented durable medical equipment, or DME, items. **Explanation:** Append modifier RR for rented DME's. Durable medical equipments is medical equipment that helps a patient to manage his activities of daily living in an easier way or that provides therapeutic benefits to a patient. The equipment this modifier is typically applicable to may be inexpensive or other routinely purchased DME, frequent or substantial servicing, certain customized items, or oxygen equipment. A few examples of DME's are crutches, wheelchairs, commodes, canes, walkers, hospital beds, patient safety equipment, and fracture and traction apparatus. **Tips:** Append modifier RR for certain services that the provider submits to durable medical equipment Medicare Administrative Contractors.
RT	**Right side (used to identify procedures performed on the right side of the body)** **Definition:** Append this modifier to the code for a procedure that a provider performs on the patient's right side. **Explanation:** Use this modifier to identify a procedure on the right side of the body. This modifier usually applies to procedures on paired organs, such as eyes, nostrils, ears, ovaries, lungs, and kidneys. **Tips:** If the provider performs the procedure on the left side of the body, append modifier LT, Left side, to identify procedures performed on the left side of the body. If the provider carries out a procedure on both sides, i.e., on each organ of an organ pair, append modifier 50, Bilateral procedure. If the provider performs the service on an organ which is not paired, such as the right side of the back, do not append modifier RT, since there is only one back.
SA	**Nurse practitioner rendering service in collaboration with a physician** **Definition:** Append modifier SA when a nurse practitioner assists the provider in a procedure, other than a surgery. **Explanation:** Use this modifier to show that a nurse practitioner assists the provider in performing a procedure. This modifier should not be used with a surgery code. Nurse practitioner may refer to a certified registered nurse or an assistant. Nurse practitioners are graduates of a nursing program. **Tips:** Use this modifier when the provider bills a service on behalf of the nurse practitioner, who assists the provider during nonsurgical services. If a nurse midwife assists the provider, append modifier SB, Nurse midwife.
SB	**Nurse midwife** **Definition:** Append modifier SB when a nurse midwife performs a service, other than a surgery. **Explanation:** Use this modifier to show that a nurse midwife assists the provider in performing a nonsurgical procedure. This modifier should not be appended to a surgery code. Nurse midwives are certified graduates of a nursing program, who specialize in midwifery i.e., those who provide patient care during pregnancy and childbirth. **Tips:** Use this modifier when the provider bills a service on behalf of the nurse midwife, who assists the provider during nonsurgical services. If a nurse practitioner assists the provider, append modifier SA, Nurse practitioner rendering service in collaboration with a physician.
SC	**Medically necessary service or supply** **Definition:** Append modifier SC to codes for services or supplies deemed medically necessary under Medicare's coverage requirements. **Explanation:** The provider appends this modifier for the supply of medically necessary services. Medically necessary services and supplies are those that help to diagnose and treat a medical condition and meet the standard care of medical practice.
SD	**Services provided by registered nurse with specialized, highly technical home infusion training** **Definition:** Append modifier SD to infusion codes when a registered nurse or RN provides infusion services to a patient with a chronic illness who continues to need intravenous infusions at home after discharge from a hospital or rehabilitation Centers. **Explanation:** Append this modifier to infusion codes when a patient, who has a chronic illness and requires intravenous therapy for long term care, receives the service from a trained infusion nurse. Services include administering intravenous therapies, monitoring the patient's condition at home, and training the patient or caregiver how to properly clean and adjust intravenous tubes. Registered nurses are graduates of a nursing program who have passed a national licensing exam. Infusion nurses obtain specialized training and credentials to administer intravenous medications. **Tips:** Do not use modifier SD with infusion codes when the infusion is administered in a hospital setting.

Mod	Modifier Description, Definition, Explanation, and Tips
SE	**State and/or federally-funded programs/services** **Definition:** Append modifier SE to codes for services that are paid by state or federal government. **Explanation:** Use modifier SE for those CPT® and HCPCS codes where the state or federal government pays the bills for the services or programs.
SF	**Second opinion ordered by a professional review organization (PRO) per section 9401, p.l. 99-272 (100% reimbursement - no Medicare deductible or coinsurance)** **Definition:** Append modifier SF to such CPT® codes where a quality improvement organization or QIO, also known as peer review organization or PRO, asks a provider to give a second opinion to confirm the decision of another provider. Codes with the SF modifier are reimbursed at 100% with no Medicare deductible or coinsurance if approved. **Explanation:** Append this code when a QIO or PRO asks a provider to give a second opinion for a decision or diagnosis made by another provider. When this modifier is applied, the patient does not pay a deducible or have to use coinsurance, and Medicare pays the provider 100% per section 9401, p.l. 99-272. **Tips:** You can use modifier SF only with certain eye surgery codes.
SG	**Ambulatory surgical Centers (ASC) facility service** **Definition:** Modifier SG appended to CPT® codes identified services provided by an ambulatory surgical Centers, which means facility fee only. Effective for services on or after January 1, 2008, the SG modifier is no longer applicable for Medicare services. ASC providers should discontinue applying the SG modifier on ASC facility claims. **Explanation:** Effective for services on or after January 1, 2008, the SG modifier is no longer applicable for Medicare services. ASC providers should discontinue applying the SG modifier on ASC facility claims.
SH	**Second concurrently administered infusion therapy** **Definition:** Append modifier SH to infusion codes for the second drug when a provider administers more than one drug at the same time by intravenous infusion. Use this code for intravenous infusion therapy codes administered in the patient's home. **Explanation:** When the provider administers two drugs at the same time by intravenous infusion in the patient's home, append this code. This modifier applies only to home infusion therapy. **Tips:** If provider administers three or more drugs by infusion therapy at the same time, use modifier SJ, Third or more concurrently administered infusion therapy.
SJ	**Third or more concurrently administered infusion therapy** **Definition:** Append modifier SJ to home infusion codes for each additional drug after the second when the provider administers multiple drugs at the same time by intravenous infusion. Use this code for intravenous infusion therapy codes administered in the patient's home. **Explanation:** When the provider administers three or more drugs at the same time by intravenous drug infusion in the patient's home, append modifier SH. This modifier applies only to home infusion therapy. **Tips:** If provider administers two drugs at the same time by intravenous infusion, use modifier SH, Second concurrently administered infusion therapy.
SK	**Member of high risk population (use only with codes for immunization)** **Definition:** Append modifier SK to immunization codes that are identified for those people who are at high risk for getting a disease, e.g., underlying medical conditions, weakened immune systems, work related, or other special circumstances that increase risk of illness. **Explanation:** When the provider provides immunization to people that he identifies as high risk, he appends modifier SK to such codes. High risk includes those with underlying medical conditions, weakened immune systems, work related, or other special circumstances that increase risk of illness. Identification of high risk individuals is determined by clinical expertise. Decisions regarding whether an individual is part of a high risk population and should receive a specific preventive item or service identified for those at high risk should be made by the attending provider. **Tips:** Do not use modifier SK for immunization codes that are given to patients who are not at high risk.

Mod	Modifier Description, Definition, Explanation, and Tips
SL	**State supplied vaccine** **Definition:** Append modifier SL to vaccine codes that a state supplies and a provider administers at no cost to eligible individuals. **Explanation:** Each state provides some vaccines free of cost. Use modifier SL with immunization procedure codes to identify those immunization materials obtained from the state Department of Health to identify that the vaccine itself was obtained at no cost to the provider or patient. **Tips:** You may use this modifier with CPT® codes in the range of 90460 to 90474, Immunization administration for vaccines and toxoids that accurately reflects the administration of the vaccines. Do not append modifier SL to the administration procedure codes. Both the procedure code for the vaccine itself and the code for administration must be submitted, and all vaccines administered on a single date of service must be reported on the same claim.
SM	**Second surgical opinion** **Definition:** Append modifier SM to evaluation and management codes for claims by a consulting provider, when another provider has requested a second opinion. **Explanation:** Use this modifier when you submit an evaluation and management code for a second opinion. The provider performing the second opinion submits the code with the modifier. **Tips:** This modifier may be used with CPT® and HCPCS level II codes. Patient initiated second opinions that relate to the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures, e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy, are covered under Medicare. In the event that the recommendation of the first and second physician differs regarding the need for surgery, or other major procedure, a third opinion is also covered. Second and third opinions are covered even though the surgery or other procedure, if performed, is determined not covered. Payment may be made for the history and examination of the patient and for other covered diagnostic services required to properly evaluate the patient's need for a procedure and to render a professional opinion. In some cases, the results of tests done by the first physician may be available to the second physician.
SN	**Third surgical opinion** **Definition:** Use this modifier when you submit an evaluation and management code for a third opinion. The provider performing the third opinion submits the code with the modifier. **Explanation:** Use this modifier when you submit an evaluation and management code for a third opinion. The provider performing the third opinion submits the code with the modifier. A third opinion might be requested when the original provider and the consultant come to different conclusions. **Tips:** Patient initiated second opinions that relate to the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures, e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy, are covered under Medicare. In the event that the recommendation of the first and second physician differs regarding the need for surgery, or other major procedure, a third opinion is also covered. Second and third opinions are covered even though the surgery or other procedure, if performed, is determined not covered. Payment may be made for the history and examination of the patient and for other covered diagnostic services required to properly evaluate the patient's need for a procedure and to render a professional opinion. In some cases, the results of tests done by the first physician may be available to the second physician.
SQ	**Item ordered by home health** **Definition:** Append this modifier to indicate that the item the provider orders is for home health service in a patient's home. **Explanation:** Append modifier SQ for an item ordered for a patient receiving home health services such as home infusion therapy, catheter care or maintenance, and respiratory therapy equipment and services. A provider may need to use the SQ modifier for medical and dressing supplies, or durable medical equipment, DME to indicate that the item is for home health use. For coverage of an item, medical documentation for the item and a dated order is generally necessary, with some items requiring preauthorization. **Tips:** This modifier is not covered by Medicare. However, some other payers may allow the claim to process under their home care benefit without a copayment when the provider appends this modifier. For rented durable medical equipment, or DME, use modifier RR, Rented equipment.

Mod	Modifier Description, Definition, Explanation, and Tips
SS	**Home infusion services provided in the infusion suite of the IV therapy provider** **Definition:** Append modifier SS when the therapy provider introduces a requisite drug at a specific dosage and at a specific rate into the patient's blood vessels at the infusion therapy providers outpatient infusion suite, a medical office that provides outpatient infusion services. **Explanation:** Append modifier SS when the provider prepares the infusion equipment or provides administration and supplies using the provider's own infusion suite. For example, a typical infusion may involve the provider using an intravenous line connected to a small mechanical pump to administer the drug at the prescribed rate for the prescribed length of time. The time recorded is for the duration of the patient service in the suite. Providers append the modifier to applicable HCPCS codes, which may include: S5522, PICC line insertion, supplies catheter excluded; S5520, PICC line kit; S5523, Midline insertion, supplies catheter excluded and S5521, Midline kit. **Tips:** This modifier is not covered by Medicare. However, some other payers may allow the claim to process under the home care benefit without a copayment. If a nurse does the infusion, use modifier SD, Services provided by registered nurse with specialized, highly technical home infusion training.
ST	**Related to trauma or injury** **Definition:** Append modifier ST to services the provider performs in the case of trauma or injury. **Explanation:** Append modifier ST to report procedures or services which the provider performs on a patient who has undergone a trauma or injury. **Tips:** This modifier is not covered by Medicare but other payers may allow the addition of the ST modifier to codes associated with a trauma patient's care, as long as the care is related to the trauma. The ST modifier may permit a supplemental payment for designated trauma Centers and enhanced rates to providers for trauma cases that meet specific criteria. If a trauma response team associated with hospital provides intensive level of examination and care that a Medicare patient requires, use code G0390, Trauma services associated with critical care services. Medicare policies provide coverage for critical care services of less than 30 minutes provided to the beneficiaries.
SU	**Procedure performed in physician's office (to denote use of facility and equipment)** **Definition:** A provider appends modifier SU to indicate where the provider performs the service in order to show that the provider uses his own facility and equipment while performing a procedure on the patient. **Explanation:** A provider appends modifier SU as an informational modifier to show the location of the service relative to the costs associated with the procedure that the provider performs for the patient. This may include the costs of running an office such as rent, equipment, supplies, and nonphysician staff costs, which may be referred to as the practice expense. **Tips:** Modifier SU is not payable by Medicare.
SV	**Pharmaceuticals delivered to patient's home but not utilized** **Definition:** A provider appends modifier SV to the pharmaceuticals or drugs that a patient receives in the home but the patient never uses them. **Explanation:** A provider appends modifier SV as an informational modifier to indicate drugs that a patient receives in his home setting but never uses them. There are various reasons for the patient not using the drugs, such as a change in the patient's condition, the patient dies, or the patient is admitted to a hospital or skilled nursing facility, or other facility. **Tips:** Modifier SV is not payable by Medicare.
SW	**Services provided by a certified diabetic educator** **Definition:** Append modifier SW to identify services that a certified diabetic educator provides to a diabetic patient. **Explanation:** Append modifier SW to denote services that a certified diabetic educator provides to a diabetic patient about lifestyle modification and self management. He may give training to the patient on how to monitor blood glucose levels, educate the patient about diet and exercise, and provide awareness about insulin treatment plans. The educator provides these services according to the instruction of the provider, who is managing the patient's diabetes condition. Certification from the provider, who is managing the patient's condition, is necessary regarding the patient's needs and implementation for the coverage of the service. **Tips:** Medicare provides coverage for diabetes self management education and training, which is provided by a certified provider in accordance with Medicare policies. Reimbursement is based on carrier judgment.

Mod	Modifier Description, Definition, Explanation, and Tips
SY	**Persons who are in close contact with member of high-risk population (use only with codes for immunization)** **Definition:** Append this modifier to codes for immunizations a patient receives who either cares for or works closely with patient who are highly prone to infection or a disease. **Explanation:** Append this informational modifier with codes for immunization of persons in close contact with patients who come under the category of high risk population, meaning patients who may have a preexisting risk factor, pathology, or decreased immunity and are more likely to be affected with an infection or disease. Append this modifier with codes for immunizations such as G0008, Administration of influenza virus vaccine, or CPT® 90371, Hepatitis B immune globulin (HBIg), human, for intramuscular use. This code includes the provider counseling the patient or family. **Tips:** Medicare does not pay for this modifier. For immunizations of a member of a high risk population, use modifier SK, Member of high risk population, use only with codes for immunization.
T1	**Left foot, second digit** **Definition:** Append modifier T1 to identify that the provider performs the procedure on the second digit, or toe, of the left foot. **Explanation:** This modifier identifies services that the provider performs on the second digit, or toe, of a patient's left foot. Use this modifier for services such as amputation, arthrodesis, or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
T2	**Left foot, third digit** **Definition:** Append modifier T2 to identify that the provider performs a procedure on the third digit, or toe, of the left foot. **Explanation:** This modifier identifies services that a provider performs on the third digit, or toe, of a patient's left foot. Use this modifier for services such as amputation, arthrodesis or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
T3	**Left foot, fourth digit** **Definition:** Append modifier T3 to identify that the provider performs a procedure on the fourth digit, or toe, of the left foot. **Explanation:** This modifier identifies services that the provider performs on the fourth digit, or toe, of a patient's left foot. Use this modifier for services such as amputation, arthrodesis or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.

Mod	Modifier Description, Definition, Explanation, and Tips
T4	**Left foot, fifth digit** **Definition:** Append modifier T4 to identify that the provider performs a procedure on the fifth digit, or toe, of the left foot. **Explanation:** This modifier identifies services that a provider performs on the fifth digit, or toe, of a patient's left foot. Use this modifier for services such as amputation, arthrodesis or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
T5	**Right foot, great toe** **Definition:** Append modifier T5 to identify that the provider performs a procedure on the great toe of the right foot. **Explanation:** This modifier identifies services that a provider performs on the great toe of a patient's right foot. Use this modifier for services such as amputation, arthrodesis (fusion) of joints, repair, revision, reconstruction, removal of a foreign body, and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the second through fifth digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the second through fifth digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
T6	**Right foot, second digit** **Definition:** Append modifier T6 to identify that the provider performs a procedure on the second digit, or toe, of the right foot. **Explanation:** This modifier identifies services that a provider performs on the second digit, or toe, of a patient's right foot. Use this modifier for services such as amputation, arthrodesis or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
T7	**Right foot, third digit** **Definition:** Append modifier T7 to identify that the provider performs a procedure on the third digit, or toe, of the right foot. **Explanation:** This modifier identifies that the provider performs the procedure on the third digit, or toe, of a patient's right foot. Use this modifier for services such as amputation, arthrodesis or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.

Mod	Modifier Description, Definition, Explanation, and Tips
T8	**Right foot, fourth digit** **Definition:** Append modifier T8 to identify that the provider performs a procedure on the fourth digit, or toe, of the right foot. **Explanation:** This modifier identifies services that the provider performs on the fourth digit, or toe, of a patient's right foot. Use this modifier for services such as amputation, arthrodesis or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. These modifiers help to prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
T9	**Right foot, fifth digit** **Definition:** Append modifier T9 to identify that the provider performs a procedure on the fifth digit, or toe, of the right foot. **Explanation:** This modifier identifies services that the provider performs on the fifth digit, or toe, of a patient's right foot. Use this modifier for services such as amputation, arthrodesis or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
TA	**Left foot, great toe** **Definition:** Append modifier TA to identify that the provider performs a procedure on the great toe of the left foot. **Explanation:** This modifier identifies services that the provider performs on the great toe of a patient's left foot. Add this modifier to codes for services such as amputation, arthrodesis, or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
TB	**Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes** **Definition:** Entities append informational modifier TB to a code for a drug or biological (a drug derived from a living organism using biotechnology) purchased at a discount under the 340B Drug Pricing Program. **Explanation:** Modifier TB indicates that a drug was purchased at a discount determined under the 340B Drug Pricing Program. Entities use this modifier for informational purposes in line with 340B program reporting rules. Biological refers to a drug or agent derived from human, animal, or microorganism components using biotechnology; examples include cells, genes, tissues, recombinant proteins, vaccines, allergens, and blood and blood components. **Tips:** Congress created the 340B Drug Discount Program (340B) in 1992 to enable healthcare providers that serve low-income and uninsured patients to purchase drugs at lower costs. The authorizing statute requires drug manufacturers that participate in the Medicaid program to offer certain outpatient drugs to covered entities listed in the statute at discounted prices. Confirm current program rules when using this modifier.

Mod	Modifier Description, Definition, Explanation, and Tips
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** **Definition:** A provider appends modifier TC to bill for the technical component of a test only. **Explanation:** Append modifier TC to report the technical component of a procedure that has both a technical and professional component, the payment for which consists of the practice and the malpractice expenses. The provider commonly appends this modifier to procedures such as injection administration, laboratory, radiology, surgery, and radiation therapy. **Tips:** Append modifier TC if the procedure reads as 1, in the PC or TC indicator on the Medicare physician fee schedule database, or MPFSDB. As modifier TC is a payment modifier, report this modifier as the first modifier.
TD	**RN** **Definition:** A provider appends this license level modifier TD when a registered nurse, or RN, provides services to a patient. A license level modifier such as TD represents the treating provider's license level that some payers base reimbursement upon. **Explanation:** A provider may use this modifier to show that a registered nurse helps the provider perform a service. This modifier should not be used with a surgery code. The modifier may also be applicable for behavioral health use, or for home health billing. The nurses may only provide services and bill for codes that fall within the scope of practice allowed by their professional training and state licensure. Check state specific requirements and payer's guidelines for all applicable uses for this code. **Tips:** If a nurse midwife assists the provider, append modifier SB, Nurse midwife. If a nurse practitioner assists the provider with a service, append modifier SA, Nurse practitioner rendering service in collaboration with a physician.
TE	**LPN/LVN** **Definition:** Append this license level modifier TE when a licensed practical nurse, LPN, or a licensed vocational nurse, LVN, provides services to a patient. A license level modifier represents the treating provider's license level that some payers base reimbursement upon. **Explanation:** A provider may use this modifier to show that a licensed practical nurse or a licensed vocational nurse helps the provider perform a service. This modifier stands for a licensed practical nurse, or LPN, in most of the United States. In other areas such as California and Texas, they are also known as a licensed vocational nurse, or LVN. An LPN or LVN takes care of patients who are ill, disabled, or injured. They work under the direction of a supervising physician. This modifier should not be used with a surgery code. The modifier may also be applicable for behavioral health use, or for home health billing. The nurses may only provide services and bill for codes that fall within the scope of practice allowed by their professional training and state licensure. Check state specific requirements and payer's guidelines for all applicable uses for this code. **Tips:** Medicare does not pay for this modifier. If a nurse midwife assists the provider, append modifier SB, Nurse midwife. If a nurse practitioner assists the provider with a service, append modifier SA, Nurse practitioner rendering service in collaboration with a physician. If a registered nurse assists the provider, append the modifier TD, RN.
TF	**Intermediate level of care** **Definition:** A provider may append this tier level modifier of TF when the patient receives services at an intermediate level of care. **Explanation:** This modifier indicates that the patient receives an intermediate level of care. A provider determines a patient's level of care by the type and amount of assistance or care the patient requires. An intermediate level is physician supervised service of a patient that typically does not need continuous care or daily therapeutic treatment. Some payers also require this modifier for physical, and or occupational therapy services, home management activities assistance, and even when reporting some tiered office level services. Medicare may even require this modifier at times such as on provider claims for demonstration services to indicate a level of complexity. **Tips:** Medicare does not pay for this modifier. If the patient receives a complex or high level of care, append modifier TG, Complex high level of care.

Mod	Modifier Description, Definition, Explanation, and Tips
TG	**Complex/high tech level of care** **Definition:** A provider appends modifier TG when a patient receives a complex or high level of care. **Explanation:** This modifier indicates that the patient receives a complex or high level of care. A provider determines a patient's level of care by the type and amount of assistance or care the patient requires. The patient with a complex or high level of care may have multiple conditions simultaneously, or a critical condition that necessitates a highly skilled and complex level of care, which one or more multispecialty providers may render in a well equipped facility. This may be combined with behavioral health problems, limited functional capabilities, and other patient needs. A provider uses this code to indicate a more intense level of service and a higher complexity of treatment. **Tips:** Medicare does not pay for this modifier. If the patient receives an intermediate level of care, append modifier TF, Intermediate level of care.
TH	**Obstetrical treatment/services, prenatal or postpartum** **Definition:** A provider appends modifier TH when a female patient receives medical care for problems related to her pregnancy and following the birth of the child. **Explanation:** This modifier indicates that a female patient receives medical care for problems related to her pregnancy and following the birth of the child. The provider may render requisite treatment for the various aspects of pregnancy, including monitoring the health of the mother and providing medical support for the recovery of the mother following a cesarean or normal delivery. **Tips:** Medicare does not pay for this modifier.
TJ	**Program group, child and/or adolescent** **Definition:** Append modifier TJ when a group of children or adolescents receive a treatment or therapy program together as a group. **Explanation:** This modifier indicates that the provider renders a service or provides therapy to a group of children or adolescent patients together at the same session. Some states may use to flag service for children's screening exams or mental health services, too. **Tips:** Medicare does not pay for this modifier.
TK	**Extra patient or passenger, non-ambulance** **Definition:** A provider appends modifier TK for a nonambulance vehicle transport of a patient with the patient's caregiver or parent, or an extra patient or passenger. **Explanation:** Use this modifier when a non ambulance vehicle such as a wheel chair van, mini bus or mobility van carries a patient and their caregiver or parent, or an extra patient or passenger. A multiple carry trip for example typically consists of two or more patients who a provider transports on the same trip. **Tips:** Medicare does not pay for this modifier.
TL	**Early intervention/individualized family service plan (IFSP)** **Definition:** A provider appends modifier TL when the provider charts out an early intervention or an individualized service plan for a patient. **Explanation:** Use modifier TL if the provider suggests an early intervention plan for a patient with a condition such as developmental delay, one of a group of disorders a patient can develop in childhood, affecting behavioral growth and development skills. The provider may also offer a customized plan that he charts out according to the specific needs of the patient and family. This type of service is often known as an individualized family service plan, or IFSP. **Tips:** The T modifiers are the HCPCS modifiers for procedures, supplies and durable medical equipment codes. Medicare does not pay for this modifier.
TM	**Individualized education program (IEP)** **Definition:** A provider appends modifier TM when the provider charts out an individualized service plan, or IEP for a patient. **Explanation:** Use modifier TM if the provider suggests a customized patient education plan that he charts out according to the specific needs of the patient and family. A comprehensive IEP treatment plan developed for a specific child may include behavior health, physical therapy, occupational therapy, speech therapy, and audiology services along with screening and assessment services and even IEP specialized transportation. **Tips:** The T modifiers are the HCPCS modifiers for procedures, supplies, and durable medical equipment codes. Medicare does not pay for this modifier.

Mod	Modifier Description, Definition, Explanation, and Tips
TN	**Rural/outside providers' customary service area** **Definition:** A provider appends this modifier to services he provides in a rural area or an area outside his normal service area. **Explanation:** A provider appends modifier TN as an informational modifier to identify services he provides in a rural area or area outside his normal service area such as outside the county in which the provider is located. This modifier may also identify such services as nonambulance transportation services, home health or hospice services, respite care services, and nursing care, or therapy services a provider renders outside their regular service area. **Tips:** This modifier may be applicable with certain transportation codes.
TP	**Medical transport, unloaded vehicle** **Definition:** A provider appends modifier TP to indicate mileage when a patient is not present in the vehicle. **Explanation:** Use this informational modifier to indicate unloaded mileage when submitting claims for nonemergency transport services such as a wheelchair van, mini bus, or mobility van. Transportation providers are normally paid for loaded mileage, or the time a patient is actually in the vehicle. An unloaded vehicle usually refers to when a patient is not present in the vehicle. Any unloaded mileage is usually inclusive in the base rate for these services. **Tips:** The T modifiers are the HCPCS modifiers for procedures, supplies, and durable medical equipment codes. Medicare does not pay for this modifier. Some payers may also require use of modifier TP with procedure codes A0021 to A0999, which identify all transportation services, including ambulance.
TQ	**Basic life support transport by a volunteer ambulance provider** **Definition:** A provider appends modifier TQ when a volunteer ambulance provider performs a basic life support transport. **Explanation:** Use this modifier when a volunteer ambulance provider performs a basic life support level of service patient transport to the requisite destination. Basic life support services, or BLS services, require the ambulance provider meet certain guidelines, which may include at least two attendants in the ambulance, one of which must be a certified emergency medical technician, or EMT, legally approved to operate all lifesaving and life-sustaining equipment. **Tips:** The T modifiers are the HCPCS modifiers for procedures, supplies, and durable medical equipment codes. Medicare does not pay for this modifier. Some payers may also require use of modifier TP with procedure codes A0021 to A0999, which identify all transportation services, including ambulance.
TR	**School-based individualized education program (IEP) services provided outside the public school district responsible for the student** **Definition:** A provider appends modifier TR when the provider performs school based customized education program services. He provides these services outside the public school district responsible for the student. **Explanation:** Use HCPCS modifier TR when the provider renders a personalized school based education program for a student. He provides this individualized education service, or IEP, outside the public school district responsible for the student. A comprehensive IEP treatment plan developed for a specific child may include behavior health, physical therapy, occupational therapy, speech therapy, and audiology services, along with screening and assessment services, and even IEP specialized transportation. **Tips:** The T modifiers are the HCPCS modifiers for procedures, supplies, and durable medical equipment codes. Medicare does not pay for this modifier.
TS	**Follow-up service** **Definition:** A provider appends modifier TS for a follow up service for a patient after a first or initial service or procedure. **Explanation:** Use this HCPCS modifier when the provider renders follow up service subsequent to the initial service or procedure. In the follow up service, the provider monitors the recovery or prognosis of the patient's condition. He may also advise additional measures to manage new symptoms that may emerge since the patient's last visit. **Tips:** The T modifiers are the HCPCS modifiers for procedures, supplies, and durable medical equipment codes. Medicare individuals with a diagnosis of prediabetes and certain risk factors may receive up to two screening tests per year and one screening test every six months. A provider reports these screening services with the appropriate Glucose code from the range 82947 to 82951 and modifier TS to indicate the service is a follow up service.

Mod	Modifier Description, Definition, Explanation, and Tips
TT	**Individualized service provided to more than one patient in same setting** **Definition:** A provider appends modifier TT when the provider offers an individualized service to more than one patient in the same setting. **Explanation:** Use the HCPCS modifier TT when the provider renders personalized service to each of two or more patients in the same setting. This modifier may identify services provided to two patients who reside in the same residence. The provider generally delivers the service simultaneously. The services can range from nursing services, to multiple passenger transports, to behavior therapy services. **Tips:** The T modifiers are the HCPCS modifiers for procedures, supplies, and durable medical equipment codes. Medicare does not pay for this modifier.
TU	**Special payment rate, overtime** **Definition:** A provider appends modifier TU for a special payment rate when the provider performs overtime work, or time worked before or after normally scheduled hours. **Explanation:** Use HCPCS modifier TU to denote the special payment rate that applies when the provider performs services overtime. For example some payers may reimburse for after hours care provided outside the normal business hours, including weekends or holidays and before 8 am and after 5 pm; Monday through Friday. In these situations the payer may require the provider to report the services with the TU modifier in order to receive the special rate. **Tips:** The T modifiers are the HCPCS modifiers for procedures, supplies, and durable medical equipment codes. Medicare does not pay for this modifier.
TV	**Special payment rates, holidays/weekends** **Definition:** A provider appends modifier TV to all services that a patient receives on holidays or weekends, to advise the payer that special payment rates may apply. **Explanation:** Append modifier TV for additional reimbursement for delivery of service at times other than regularly scheduled office hours. This may include, such situations as off hours care, or extended care on a weekend or holiday, when the office is normally closed. **Tips:** Modifier TV is not payable by Medicare. A provider may use modifier TV for a patient who requires seven day per week home care service. Medicaid and other insurers may pay a higher rate for home care visits made on recognized holidays if they are preauthorized.
TW	**Back-up equipment** **Definition:** A provider appends modifier TW to report all types of back up durable medical equipment, or DME. Back up DME, is a secondary piece of equipment that is identical or similar to DME that is already in use. It meets the same medical need for a patient but is provided as a precaution for an emergency situation in case the primary piece of equipment fails. **Explanation:** A provider appends modifier TW for back up durable medical equipment. DME is medical equipment that helps a patient to manage his activities of daily living in an easier way or that provides therapeutic benefits to a patient. A few examples of back up DME's are wheelchairs, oxygen and other respiratory apparatus such as a backup ventilator, other patient monitoring devices, patient safety equipment, ambulatory infusion pumps, fracture and traction apparatus, and artificial kidney machines. **Tips:** Payers may require providers to append modifier TW to identify back up DME when requesting prior authorization for the item, as well as when submitting claims. Some payers may also request the TW modifier for Orthotic and Prosthetic Devices. Modifier TW is not payable by Medicare.

Mod	Modifier Description, Definition, Explanation, and Tips
U1	**Medicaid level of care 1, as defined by each state** **Definition:** A provider appends modifier U1 to report the services related to a Medicaid level of care 1, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U1 according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service such as a healthcare home programs, comprehensive care, coordination and planning, and initial plan; or skilled nursing services A or B level of care. A provider may also use this code when he does not identify any behavioral health need during screening or evaluation of a patient. Identification of behavioral health need means that the provider, who is evaluating the patient, identifies a patient who is typically a child with a significant or potential behavioral health services need. **Tips:** The definition of modifier U1 may depend upon the procedure code the provider appends the modifier to. For example, in Minnesota the U1 modifier may define Care coordination, basic complexity level when a provider reports with Medical home program, comprehensive care coordination and planning codes S0280 or S0281, but it may mean substance abuse treatment for a special population or clients with children when the provider reports the modifier with H2035, Alcohol And/Or Other Drug Treatment Program, Per Hour. In compliance with Texas, or TX Medicaid, a provider appends modifier U1 to U3, with all delivery claims with codes, 59409, Vaginal delivery only, with or without episiotomy and or forceps, 59612, Vaginal delivery only, after previous cesarean delivery with or without episiotomy and or forceps, 59514, Cesarean delivery only, and 59620, Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery. Providers in Minnesota follow healthcare homes payment methodology to determine whether a patient's condition meets the requirement for a major chronic condition. At this time, the tier reflects the number of major chronic condition groups the patient has and a provider uses a modifier to reflect the projected intensity of care coordination services the patient will require. A provider uses modifier U1 for patients who have one to three major chronic condition groups, to indicate the patient is in Tier one.
U2	**Medicaid level of care 2, as defined by each state** **Definition:** A provider appends modifier U2 to report the services related to a Medicaid level of care 2, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U2 according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service such as a healthcare home programs, comprehensive care, coordination and planning, and initial plan; or skilled nursing services A or B level of care. A provider may also use this code when he identifies any behavioral health need during screening or evaluation of a patient. Identification of behavioral health need means that the provider, who is evaluating the patient, identifies a patient who is typically a child with a significant or potential behavioral health services need. **Tips:** In compliance with Texas, or TX Medicaid, a provider appends modifier U1 to U3, with all delivery claims with codes, 59409, Vaginal delivery only, with or without episiotomy and or forceps, 59612, Vaginal delivery only, after previous cesarean delivery with or without episiotomy and or forceps, 59514, Cesarean delivery only, and 59620, Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery. Providers in Minnesota follow healthcare homes payment methodology to determine whether a patient's condition meets the requirement for a major chronic condition. At this time, the tier reflects the number of major chronic condition groups the patient has and a provider uses a modifier to reflect the projected intensity of care coordination services the patient will require. A provider uses modifier U2 for patients who have seven to nine major chronic condition groups, to indicate the patient is in Tier three.

Mod	Modifier Description, Definition, Explanation, and Tips
U3	**Medicaid level of care 3, as defined by each state** **Definition:** A provider appends modifier U3 to report the services related to a Medicaid level of care 3, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U3 according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as a healthcare home programs, comprehensive care, coordination and planning, and initial plan; or skilled nursing services A or B level of care. A provider may use this code for a mental health services encounter when he performs a behavioral health screening or evaluation of a patient. Identification of behavioral health need means that the provider, who is evaluating the patient, identifies a patient who is typically a child with a significant or potential behavioral health services need. **Tips:** Professional claims for Medicare demonstration services may include optional supplemental factor modifier U3. Supplemental complexity modifiers means that the provider will be eligible to receive a 15 percent or 30 percent increase in his healthcare homes care coordination payment for certain more complex patients. To indicate complexity, providers in Minnesota may use modifier U3, Primary language non English. This means that the English language skills are not sufficient to discuss and create complicated care plans, complex care choices, and options. This may apply to the patient or to a caregiver of a dependent patient. This also includes those patients or caregivers who are hearing impaired and require a sign language interpreter or use an augmentative communication device. Providers must consider whether the language barrier is significant enough to prevent a discussion with a patient's care team for care coordination services and report this modifier.
U4	**Medicaid level of care 4, as defined by each state** **Definition:** A provider appends modifier U4 to report the services related to a Medicaid level of care 4, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U4 according to their states specific requirements. A provider may use this code when he identifies any behavioral health need during screening or evaluation of a patient. Identification of behavioral health need means that the provider, who is evaluating the patient, identifies a patient who is a child with a significant or potential behavioral health services need. **Tips:** Professional claims for Medicare demonstration services may include optional supplemental factor modifier U4. Supplemental complexity modifiers mean that the provider will be eligible to receive a 15 percent or 30 percent increase in his healthcare homes care coordination payment for certain more complex patients. To indicate complexity, providers in Minnesota may use modifier U4 for severe and persistent mental illness. This means the patient has an active diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder as per Minnesota statute. This may apply to the patient or to a caregiver of a dependent patient. If a patient has either one of the supplemental complexity modifiers, the allowable charge for the tier payment at this time increases by 15 percent. If both complexity modifiers are present, the allowable charge for the tier payment increases by 30 percent. Providers follow the guidelines provided by the Minnesota healthcare homes payment methodology to determine whether a patient's situation meets the level of warranting a supplemental complexity factor.
U5	**Medicaid level of care 5, as defined by each state** **Definition:** A provider appends modifier U5 to report the services related to a Medicaid level of care 5, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U5 according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as a healthcare home programs, comprehensive care, coordination and planning, and initial plan, or an increased substance abuse treatment with medical services. A provider may use this code for a mental health services encounter when he performs a behavioral health screening or evaluation of a patient. Identification of behavioral health need means that the provider, who is evaluating the patient, identifies a patient who is typically a child with a significant or potential behavioral health services need. **Tips:** A provider uses U5 as a local modifier with codes for obstetrical and gynecological services in Illinois. The modifier flags the services as Direct Access services, or service available without a referral. For the Kansas Medical Assistance Program, or KMAP, a provider can append the U5 modifier to identify a Targeted Case Management service when appropriate, typically in the case of the frail and elderly who require a higher level of service. Modifier U5 is not payable by Medicare.

Mod	Modifier Description, Definition, Explanation, and Tips
U6	**Medicaid level of care 6, as defined by each state** **Definition:** A provider appends modifier U6 to report the services related to a Medicaid level of care 6, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U6 according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as a healthcare home programs, comprehensive care, coordination and planning, and initial plan; or for increased service such as an authorized podiatry encounter. A provider may use this code when he identifies any behavioral health need during screening or evaluation of a patient. Identification of behavioral health need means that the provider, who is evaluating the patient, identifies a patient who is a child with a significant or potential behavioral health services need. **Tips:** An Illinois provider may use U6 as a local modifier with codes for service provided within 60 days of hospital discharge such as a therapy visit within 60 days of hospital discharge. One use of the modifier for California Medicaid is to indicate EC pills, or emergency contraceptive pills. When filing Arkansas Medicaid family planning claims for provider services in an outpatient clinic, the modifier U6, identifies a basic family planning visit. Modifier U6 is not payable by Medicare.
U7	**Medicaid level of care 7, as defined by each state** **Definition:** A provider appends modifier U7 to report the services related to a Medicaid level of care 7, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U7 according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as a healthcare home programs, comprehensive care, coordination and planning, and initial plan; or an increased service such as an All-inclusive Clinic Visit. A provider may use this code for a mental health services encounter when he performs a behavioral health screening or evaluation of a patient. Identification of behavioral health need means that the provider, who is evaluating the patient, identifies a patient who is typically a child with a significant or potential behavioral health services need. **Tips:** Illinois uses U7 as a local modifier to flag the services for pregnancy resulting from incest. California Medicaid, applies the U7 modifier to denote services rendered by a Physician Assistant, PA. A provider appends the U7 modifier in Indiana for all waiver services. Modifier U7 is not payable by Medicare.
U8	**Medicaid level of care 8, as defined by each state** **Definition:** A provider appends modifier U8 to report the services related to a Medicaid level of care 8, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U8 according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as a healthcare home programs, comprehensive care, coordination and planning, and initial plan; or an all inclusive service. A provider may use this code when he identifies any behavioral health need during screening or evaluation of a patient. Identification of behavioral health need means that the provider, who is evaluating the patient, identifies a patient who is a child with a significant or potential behavioral health services need. **Tips:** Illinois uses U8 as a local modifier with codes for pregnancy threatening the mother's life; where New York uses the modifier to flag a delivery prior to 39 weeks of gestation. Modifier U8 is not payable by Medicare.

Mod	Modifier Description, Definition, Explanation, and Tips
U9	**Medicaid level of care 9, as defined by each state** **Definition:** A provider appends modifier U9 to report the services related to a Medicaid level of care 9, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U9 according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as a healthcare home programs, comprehensive care, coordination and planning, and initial plan; or for such services as when he evaluates, diagnoses, and treats patients with vision problems, for example. **Tips:** Although Medicaid pays for routine vision care services, such as eyeglasses and routine eye care exams, Medicare generally does not. Therefore, Medicaid requires providers to apply the Medicaid standard fee schedule amounts when submitting claims for routine vision care services to recipients who are enrolled in both Medicaid and Medicare.
UA	**Medicaid level of care 10, as defined by each state** **Definition:** A provider appends modifier UA to report the services related to a Medicaid level of care 10, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier UA according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such to designate that the patient was admitted to the hospital or transferred to another hospital from the ED. **Tips:** Modifier UA is a Medicaid only modifier. Claims using this modifier submitted for members of plans other than Medicaid will be denied. Some providers use the UA modifier for surgical or nongeneral anesthesia related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code. However, when a provider reports this modifier with heroin detoxification code, H0014, Alcohol and/or drug services; ambulatory detoxification, the UA modifier indicates the outpatient heroin detoxification services per visit, days 1 – 7; something completely different.
UB	**Medicaid level of care 11, as defined by each state** **Definition:** A provider appends modifier UB to report the services related to a Medicaid level of care 11, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier UB according to their state specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as identifying that a transport is of a critically ill or injured patient over 24 months of age. The UB modifier can also indicate that the age of the patient is less than 21 or greater than 59, as for some Vision care services. **Tips:** Ohio for example uses the UB modifier to describe a Comprehensive ophthalmologic service for an individual younger than 21 or older than 59. In this situation the modifier is applicable only to CPT® procedure codes 92004, Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits, and 92014, Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits. In California, a provider uses this code to identify surgical or general anesthesia related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code. However, when a provider reports this modifier with heroin detoxification code, H0014, Alcohol and/or drug services; ambulatory detoxification, the UB modifier indicates outpatient heroin detoxification services per visit, days 8 – 21. In Georgia, modifier UB indicates a delivery is a medically necessary delivery prior to 39 weeks of gestation. Wisconsin providers append the UB modifier to some Mental Health, Telemedical and Health and Behavior procedure codes to indicate an Advanced Practice Nurse provides the service.

Mod	Modifier Description, Definition, Explanation, and Tips
UC	**Medicaid level of care 12, as defined by each state** **Definition:** A provider appends modifier UC to report the services related to the Medicaid level of care 12, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier UC according to their state specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as identifying a Clinical Nurse Specialist performs the service or to ensure payment goes to a Community Mental Health Services Program Provider, or CMHSP, and not to the rendering provider as this modifier indicates the CMHSP is billing Medicaid fee for service for a Community Based Services Waiver Program, or CWP beneficiary. **Tips:** Medicaid rules governing professional services within the Ohio Administrative Code, or OAC, indicate that one may report modifier UC along with 26 if the professional component for radiology procedure codes is provided by an advanced practice nurse, or APN, operating within the APN's scope of practice.
UD	**Medicaid level of care 13, as defined by each state** **Definition:** A provider appends modifier UD to report the services related to a Medicaid level of care 13, as defined by each state. A state may also use this code to have the provider identify a type of service or patient situation. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. See state specific requirements for use of this code. **Explanation:** A provider appends modifier UD according to their state specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as to denote services provided or drugs purchased under a particular program or when billing for an attending ED provider evaluation and management, or E and M service, to designate that the patient was discharged from the hospital and not admitted. **Tips:** Modifier UD is a Medicaid only modifier. Claims using this modifier submitted for members of plans other than Medicaid will be denied.
UE	**Used durable medical equipment** **Definition:** A provider appends modifier UE to identify an item as used durable medical equipment, or DME, that a patient purchases. DME is medical equipment that helps a patient to manage his activities of daily living in an easier way or that provides therapeutic benefits to a patient. **Explanation:** A provider appends modifier UE to codes for used DME. DME helps the patient to manage his activities of daily living in an easier way. The codes this modifier is typically applicable to are defined as Inexpensive or Routinely Purchased Items, or IRP Items, Capped Rental Items, Items Requiring Frequent and Substantial Servicing, or Oxygen Equipment. A few examples of DME's are crutches, wheelchairs, commodes, canes, walkers, hospital beds, patient safety equipment, and fracture and traction apparatus. **Tips:** Using modifier UE indicates that the provider is furnishing the patient with purchased used durable medical equipment. A provider uses modifier RR, Rented item, if the item is being rented by the patient and modifier NU, New purchased item, if the item is purchased new by the patient.
UF	**Services provided in the morning** **Definition:** A provider appends modifier UF to report that the services that the patient receives from the provider are occurring the morning. **Explanation:** Append modifier UF to identify that the provider sees the patient in the morning. This modifier typically defines services the patient receives between 6 a.m. to 11:59 a.m. and can include such services as provider professional services as well as home visits for mechanical ventilation care; nursing care, assessment or evaluation. **Tips:** Modifier UF is not payable by Medicare.
UG	**Services provided in the afternoon** **Definition:** A provider appends modifier UG to report that the services that the patient receives from the provider occur in the afternoon. **Explanation:** Append modifier UG to cover services that the patient receives by the provider in the afternoon. This modifier typically defines services the patient receives between 12 p.m. to 5:59 p.m. and can include such services as provider professional services as well as home visits for mechanical ventilation care; nursing care, assessment or evaluation. **Tips:** Modifier UG is not payable by Medicare.

Mod	Modifier Description, Definition, Explanation, and Tips
UH	**Services provided in the evening** **Definition:** A provider appends modifier UH to report that the services that the patient receives from the provider occur in the evening. **Explanation:** Append modifier UH to identify that the provider sees the patient in the evening. This modifier typically defines services the patient receives between 6 p.m. to 11:59 p.m. and can include such services as provider professional services as well as home visits for mechanical ventilation care; nursing care, assessment or evaluation. **Tips:** Modifier UH is not payable by Medicare.
UJ	**Services provided at night** **Definition:** A provider appends modifier UJ to report that the services that the patient receives from the provider occur at night. **Explanation:** Append modifier UJ to cover services that the patient receives by the provider at night. This modifier typically defines services the patient receives between 12 a.m. to 5:59 a.m. and can include such services as provider professional services as well as home visits for mechanical ventilation care; nursing care, assessment or evaluation. **Tips:** Modifier UJ is not payable by Medicare.
UK	**Services provided on behalf of the client to someone other than the client (collateral relationship)** **Definition:** A provider appends modifier UK to report services that the provider performs for someone other than the client, on behalf of the client. **Explanation:** Append modifier UK to cover the services that the provider renders to someone other than the client, on behalf of the client. A provider may need to report this modifier for mental health services such as, a family or couple visit without the client present; or when using H0046, Mental health services, not otherwise specified. This code may also be necessary if submitting newborn care services under the mother's ID information. **Tips:** Modifier UK is not payable by Medicare.
UN	**Two patients served** **Definition:** A provider appends modifier UN when two patients receive services at the same location such as portable X-ray services for two Medicare patients at the same location. The provider serves the patients during a single trip that the portable X-ray supplier makes to a particular location. **Explanation:** A provider reports this modifier when he provides services to patients at the same location. A provider may for example append the modifier with HCPCS code R0075, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen, when submitting Medicare portable X-rays. When you report this code combination, R0075 with modifier UN, the total Medicare payment for a single patient service covers both patients. **Tips:** If the provider serves only one patient in the example given, he reports a different HCPCS code R0070, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen, and no modifier, since the descriptor for this code states that the service is for one patient seen. Medicare allows a single transportation payment for each trip the portable X-ray supplier makes to a particular location.
UP	**Three patients served** **Definition:** A provider appends modifier UP when three patients receive services at the same location such as for portable X-ray services for three Medicare patients at the same location. The provider serves the patients during a single trip that the portable X-ray supplier makes to a particular location. **Explanation:** A provider reports this modifier when he provides services to three patients at the same location. A provider may for example append the modifier with HCPCS code R0075, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen, when submitting Medicare portable X-rays. **Tips:** If the provider serves only one patient, he reports a different HCPCS code R0070, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen, and no modifier, since the descriptor for this code states that the service is for one patient seen. Medicare allows a single transportation payment for each trip the portable X-ray supplier makes to a particular location.

Mod	Modifier Description, Definition, Explanation, and Tips
UQ	**Four patients served** **Definition:** A provider appends modifier UQ when four patients receive services at the same location such as for portable X-ray services for four Medicare patients at the same location. The provider serves the patients during a single trip that the portable X-ray supplier makes to a particular location. **Explanation:** A provider reports this modifier when he provides services to four patients at the same location. A provider may for example append the modifier with HCPCS code R0075, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen, when submitting Medicare portable X-rays. **Tips:** If the provider serves only one patient, he reports a different HCPCS code R0070, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen, and no modifier, since the descriptor for this code states that the service is for one patient seen. Medicare allows a single transportation payment for each trip the portable X-ray supplier makes to a particular location.
UR	**Five patients served** **Definition:** A provider appends modifier UR when five patients receive services at the same location such as for portable X-ray services for five Medicare patients at the same location. The provider serves the patients during a single trip that the portable X-ray supplier makes to a particular location. **Explanation:** A provider reports this modifier when he provides services to five patients at the same location. A provider may for example append the modifier with HCPCS code R0075, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen, when submitting Medicare portable X-rays. **Tips:** If the provider serves only one patient, he reports a different HCPCS code R0070, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen, and no modifier, since the descriptor for this code states that the service is for one patient seen. Medicare allows a single transportation payment for each trip the portable X-ray supplier makes to a particular location.
US	**Six or more patients served** **Definition:** A provider appends modifier US when six patients receive services at the same location such as for portable X-ray services for six Medicare patients at the same location. The provider serves the patients during a single trip that the portable X-ray supplier makes to a particular location. **Explanation:** A provider reports this modifier when he provides services to six patients at the same location. A provider may for example append the modifier with HCPCS code R0075, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen, when submitting Medicare portable X-rays. **Tips:** If the provider serves only one patient, he reports a different HCPCS code R0070, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen, and no modifier, since the descriptor for this code states that the service is for one patient seen. Medicare allows a single transportation payment for each trip the portable X-ray supplier makes to a particular location.
V1	**Demonstration modifier 1** **Definition:** Append modifier V1 to indicate that the service/procedure is part of a demonstration. **Explanation:** CMS conducts and sponsors demonstration projects to test and measure the effect of potential program changes. The demonstrations study the likely impact of new methods of service delivery, coverage of new types of service, and new payment approaches on beneficiaries, providers, health plans, states, and the Medicare Trust Funds. Append the appropriate modifier when the services involve demonstration of a procedure/service to allow accurate identification and documentation for Medicare beneficiaries enrolled in the demonstration. **Tips:** This modifier is part of a series of similar modifiers that indicates demonstration services/procedures. It is advisable to check payer guidelines for use of any of these modifiers.
V2	**Demonstration modifier 2** **Definition:** Append modifier V2 to indicate that the service/procedure is part of a demonstration. **Explanation:** CMS conducts and sponsors demonstration projects to test and measure the effect of potential program changes. The demonstrations study the likely impact of new methods of service delivery, coverage of new types of service, and new payment approaches on beneficiaries, providers, health plans, states, and the Medicare Trust Funds. Append the appropriate modifier when the services involve demonstration of a procedure/service to allow accurate identification and documentation for Medicare beneficiaries enrolled in the demonstration. **Tips:** This modifier is part of a series of similar modifiers that indicates demonstration services/procedures. It is advisable to check payer guidelines for use of any of these modifiers.

Mod	Modifier Description, Definition, Explanation, and Tips
V3	**Demonstration modifier 3** **Definition:** Append modifier V3 to indicate that the service/procedure is part of a demonstration. **Explanation:** CMS conducts and sponsors demonstration projects to test and measure the effect of potential program changes. The demonstrations study the likely impact of new methods of service delivery, coverage of new types of service, and new payment approaches on beneficiaries, providers, health plans, states, and the Medicare Trust Funds. Append the appropriate modifier when the services involve demonstration of a procedure/service to allow accurate identification and documentation for Medicare beneficiaries enrolled in the demonstration. **Tips:** This modifier is part of a series of similar modifiers that indicates demonstration services/procedures. It is advisable to check payer guidelines for use of any of these modifiers.
V4	**Demonstration modifier 4** **Definition:** Append modifier V4 to indicate that the service/procedure is part of a demonstration. **Explanation:** CMS conducts and sponsors demonstration projects to test and measure the effect of potential program changes. The demonstrations study the likely impact of new methods of service delivery, coverage of new types of service, and new payment approaches on beneficiaries, providers, health plans, states, and the Medicare Trust Funds. Append the appropriate modifier when the services involve demonstration of a procedure/service to allow accurate identification and documentation for Medicare beneficiaries enrolled in the demonstration. **Tips:** This modifier is part of a series of similar modifiers that indicates demonstration services/procedures. It is advisable to check payer guidelines for use of any of these modifiers.
V5	**Vascular catheter (alone or with any other vascular access)** **Definition:** A provider appends modifier V5 to report a vascular catheter he uses to perform hemodialysis for a patient such as one with end stage renal disease, or ESRD. The provider may use the catheter alone or with another vascular access. **Explanation:** A provider appends this modifier to report the type of vascular access he uses for the delivery of hemodialysis to an ESRD patient. The provider uses the V5 modifier when he uses a vascular catheter for the ESRD patient's hemodialysis service and he uses this access with or without another vascular access to perform the service. ESRD defines the final stage of kidney failure where a patient is not able to live without dialysis or a transplant because of the complete or nearly complete irreversible loss of renal function. ESRD is also referred to as end stage kidney disease, end stage kidney failure, and end stage renal failure. Hemodialysis is a blood filtration procedure for a patient with this advanced, permanent kidney failure. During typical hemodialysis, a dialysis machine removes harmful wastes, salts, and fluid from the blood that would normally be eliminated in the urine. A provider uses a vascular catheter, or a flexible tube that he inserts into a blood vessel through which he can remove and return blood during hemodialysis, or perform other services such as pass instruments, draw blood, or instill fluids. **Tips:** ESRD claims for hemodialysis must indicate the type of vascular access the provider uses for the delivery of the hemodialysis at the last hemodialysis session of the month.
V6	**Arteriovenous graft (or other vascular access not including a vascular catheter)** **Definition:** A provider appends modifier V6 to report an arteriovenous graft, or other vascular access he uses to perform hemodialysis for a patient such as one with end stage renal disease, or ESRD. The provider may use the graft alone or with another vascular access but he does not use a vascular catheter for this service. **Explanation:** A provider appends this modifier to report the type of vascular access he uses for the delivery of hemodialysis to a patient such as an ESRD patient. The provider uses the V6 modifier when he uses an arteriovenous graft, or other vascular access but not a vascular catheter to perform an ESRD patient's hemodialysis service. The provider uses an arteriovenous graft, for the hemodialysis service by surgically connecting a vein to an artery using a soft plastic tube, or an organic material from a person or animal. The provider then uses this access to remove and return blood during the hemodialysis service. ESRD defines the final stage of kidney failure where a patient is not able to live without dialysis or a transplant because of the complete or nearly complete irreversible loss of renal function. ESRD is also referred to as end stage kidney disease, end stage kidney failure, and end stage renal failure. Hemodialysis is a blood filtration procedure for a patient with this advanced, permanent kidney failure. During typical hemodialysis, a dialysis machine removes harmful wastes, salts, and fluid from the blood that would normally be eliminated in the urine. **Tips:** ESRD claims for hemodialysis with must indicate the type of vascular access the provider uses for the delivery of the hemodialysis at the last hemodialysis session of the month.

Mod	Modifier Description, Definition, Explanation, and Tips
V7	**Arteriovenous fistula only (in use with two needles)** **Definition:** A provider appends modifier V7 to represent an arteriovenous fistula, in use with two needles to perform hemodialysis for a patient such as one with end stage renal disease, or ESRD. The provider does not use a vascular catheter, arteriovenous graft, or other vascular access when he reports this service. **Explanation:** A provider appends this modifier to report the type of vascular access he uses for the delivery of hemodialysis to a patient such as an ESRD patient. A provider appends modifier V7 to represent an arteriovenous fistula, in use with two needles. The provider then uses this access to remove and return blood during the hemodialysis service. ESRD defines the final stage of kidney failure where a patient is not able to live without dialysis or a transplant because of the complete or nearly complete irreversible loss of renal function. ESRD is also referred to as end stage kidney disease, end stage kidney failure, and end stage renal failure. Hemodialysis is a blood filtration procedure for a patient with this advanced, permanent kidney failure. During typical hemodialysis, a dialysis machine removes harmful wastes, salts, and fluid from the blood that would normally be eliminated in the urine. An arteriovenous fistula is a tract or abnormal passageway that is not supposed to be there that connects a coronary artery to the pulmonary venous circulation. **Tips:** ESRD claims for hemodialysis must indicate the type of vascular access the provider uses for the delivery of the hemodialysis at the last hemodialysis session of the month.
VM	**Medicare diabetes prevention program (MDPP) virtual make-up session** **Definition:** Append modifier VM to a code when a provider delivers an in-person virtual make-up session to a beneficiary who missed a group-based, classroom-style, core Medicare diabetes prevention program (MDPP) session. **Explanation:** Modifier VM indicates that the provider electronically delivered a make-up session as part of an established MDPP curriculum to a patient who missed a face-to-face group class. **Tips:** The MDPP is a six-month CDC-approved curriculum consisting of a minimum of 16 intensive “core” educational sessions delivered to a group of patients with prediabetes in a classroom-style setting aimed at preventing progression to type 2 diabetes mellitus. The curriculum provides training in long-term dietary change, increased physical activity, and behavior modification strategies for weight control. Less intensive follow-up monthly sessions help ensure that the participants maintain healthy behaviors. The primary goal of the expanded model is at least 5 percent average weight loss by participants.
VP	**Aphakic patient** **Definition:** A provider appends modifier VP to represent an aphakic patient, or a patient without a lens in the eye. **Explanation:** A provider appends modifier VP to represent an aphakic patient. An aphakic patient is one who has lost the lens of his eye, due to reasons such as surgical removal, an intervening ulcer, or an anomaly from birth. This may lead to problems related to the eye, such as, far sightedness and a loss of accommodation, or adjustment of the eye to view different objects. There may be complications which arise due to aphakia. These may include detachment of the retina and glaucoma. **Tips:** Modifier VP is informational only and you may report it with different types of service such as medical care, surgery, consultation, diagnostic radiology, anesthesia, assistant at surgery, other medical items or services, ambulatory surgical Centers, or facility usage for surgical services. If you report modifier VP with codes for any other types of service, the payer may return the claim as unprocessable. The provider may need to resubmit as a new claim without the modifier.
X1	**Continuous/broad services** **Definition:** Append modifier X1 to a code for continuing, broad or comprehensive care services, typically for a patient with multiple chronic conditions, with no anticipated endpoint, provided by primary care and specialty providers. **Explanation:** Modifier X1 defines a patient relationship category in which either a primary care physician or specialist, either directly or coordinating care by others, provide continuous broad or comprehensive care, potentially dealing with multiple chronic health issues, and the patient’s health problems are such that no endpoint (cure or other endpoint) is anticipated. **Tips:** Patient relationship categories facilitate the attribution of patients and care episodes to clinicians who serve patients in different roles as part of the assessment of the cost of care.
X2	**Continuous/focused services** **Definition:** Append modifier X2 to a code for ongoing management of a chronic disease with no anticipated endpoint, typically provided by a specialist. **Explanation:** Modifier X2 defines a patient relationship category in which typically a specialist provides ongoing care and management for a specific chronic health issue, such as rheumatoid arthritis, heart disease, or diabetes, and no endpoint (cure or other endpoint) is anticipated. **Tips:** Patient relationship categories facilitate the attribution of patients and care episodes to clinicians who serve patients in different roles as part of the assessment of the cost of care.

Mod	Modifier Description, Definition, Explanation, and Tips
X3	**Episodic/broad services** **Definition:** Append modifier X3 to a code for services rendered by a provider with broad responsibility (i.e., oversight/management) for comprehensive and general care limited to a specific period or circumstance, such as a hospital admission. **Explanation:** Modifier X3 defines a patient relationship category in which a provider, such as a hospitalist, renders general and comprehensive care and management to a patient for a limited period of time, such as a hospitalization. **Tips:** Patient relationship categories facilitate the attribution of patients and care episodes to clinicians who serve patients in different roles as part of the assessment of the cost of care.
X4	**Episodic/focused services** **Definition:** Append modifier X4 to a code for focused care services, such as surgical intervention or radiotherapy, for acute or chronic conditions rendered by a provider for a limited or defined period of time. **Explanation:** Modifier X4 defines a patient relationship category in which a provider, such as a surgeon or radiation oncologist, renders care and management or intervention to a patient for a specific chronic or acute condition over a defined or limited period of time. **Tips:** Patient relationship categories facilitate the attribution of patients and care episodes to clinicians who serve patients in different roles as part of the assessment of the cost of care.
X5	**Diagnostic services requested by another clinician** **Definition:** Append modifier X5 to a code for primarily diagnostic services, such as interpreting an imaging study, rendered by a provider only as ordered by another clinician. **Explanation:** Modifier X5 indicates that a provider renders a service, primarily diagnostic, to a patient only at the request or order of another provider. The service could be something like interpretation of an imaging study, EKG, or laboratory test. The services may also be subsequent or related services as requested or ordered by another provider. **Tips:** This patient relationship category is reported for patient relationships that may not be adequately captured by modifiers X1-X4. Patient relationship categories facilitate the attribution of patients and care episodes to clinicians who serve patients in different roles as part of the assessment of the cost of care.
XE	**Separate encounter, a service that is distinct because it occurred during a separate encounter** **Definition:** Append modifier XE to services that the provider performs for a patient at separate encounters on the same date of service. **Explanation:** A provider appends this modifier when the provider performs services on a patient at separate patient encounters that occur on the same date of service. Modifier XE defines a subset of the modifier 59, Distinct Procedural Service. CPT® instructions state that a provider should not use modifier 59 when a more descriptive modifier is available, such as modifier XE, for billing certain codes at high risk for incorrect billing. For example, a provider may identify a particular code pair as payable only with modifier XE but not modifier 59. Modifier XE is a more selective version of modifier 59 so it would be incorrect to include both modifiers on the same line. The combination of an alternative specific modifier with a general less specific modifier creates additional evaluation for both reporting and editing. Modifier XE is a valid modifier even before national edits are in place, so contractors are not prohibited from requiring the use of this selective modifier as an alternative to the general modifier 59 when necessary by local program integrity and compliance needs. **Tips:** Contractors recognize modifier XE as a separate modifier and the system allows a provider to report multiple lines with modifier 59 and the XE modifier. However, the system aggregates lines with the XE modifier along with lines containing modifier 59, whenever it collects the modifier 59 lines.
XP	**Separate practitioner, a service that is distinct because it was performed by a different practitioner** **Definition:** Append modifier XP to identify a service that a different provider performs on the patient. **Explanation:** A provider appends this modifier to identify a distinct service that a patient receives from a different provider who performs the service on the patient. Modifier XP defines a subset of the modifier 59, Distinct Procedural Service. CPT® instructions state that a provider should not use modifier 59 when a more descriptive modifier is available, such as modifier XP, for billing certain codes at high risk for incorrect billing. Modifier XP is a more selective version of modifier 59 so it would be incorrect to include both modifiers on the same line. The combination of an alternative specific modifier with a general less specific modifier creates additional evaluation for both reporting and editing. Modifier XP is a valid modifier even before national edits are in place, so contractors are not prohibited from requiring the use of these selective modifiers an alternative to the general modifier 59 when necessary by local program integrity and compliance needs. **Tips:** Contractors recognize modifier XP as a separate modifier and the system allows a provider to report multiple lines with modifier 59 and XP modifier. However, the system aggregates lines with the XP modifier along with lines containing modifier 59 whenever it collects modifier 59 lines.

Mod	Modifier Description, Definition, Explanation, and Tips
XS	**Separate structure, a service that is distinct because it was performed on a separate organ/structure** **Definition:** Append modifier XS to a service that the provider performs for a patient on a separate organ or structure. **Explanation:** A provider appends this modifier to identify a distinct service when the provider performs services on a patient on different organs or structures. Modifier XS defines a subset of the modifier 59, Distinct Procedural Service. CPT® instructions state that a provider should not use modifier 59 when a more descriptive modifier is available, such as modifier XS, for billing certain codes at high risk for incorrect billing. Modifier XS is a more selective version of modifier 59 so it would be incorrect to include both modifiers on the same line. The combination of an alternative specific modifier with a general less specific modifier creates additional evaluation for both reporting and editing. Modifier XS is a valid modifier even before national edits are in place, so contractors are not prohibited from requiring the use of this selective modifier as an alternative to the general modifier 59 when necessary by local program integrity and compliance needs. **Tips:** Contractors recognize modifier XS as a separate modifier and the system allows a provider to report multiple lines with modifier 59 and XS modifier. However, the system aggregates lines with the XS modifier along with lines containing modifier 59 whenever it collects the modifier 59 lines.
XU	**Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service** **Definition:** Append modifier XU to a service that is distinct because it does not overlap with the usual components of the main service. **Explanation:** A provider appends this modifier to identify the service as a distinct service, as the service the provider performs does not overlap with the unusual components of the main, or primary, service he renders to a patient. Modifier XU defines a subset of the modifier 59, Distinct Procedural Service. CPT® instructions state that a provider should not use modifier 59 when a more descriptive modifier is available, such as modifier XU, for billing certain codes at high risk for incorrect billing. Modifier XU is a more selective version of modifier 59 so it would be incorrect to include both modifiers on the same line. The combination of an alternative specific modifier with a general less specific modifier creates additional evaluation for both reporting and editing. Modifier XU is a valid modifier even before national edits are in place, so contractors are not prohibited from requiring the use of this selective modifier as an alternative to the general modifier 59 when necessary by local program integrity and compliance needs. **Tips:** Contractors recognize modifier XU as a separate modifier and the system allows a provider to report multiple lines with modifier 59 and XU modifier. However, the system aggregates lines with the XU modifier along with lines containing modifier 59 whenever it collects modifier 59 lines.

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