Modifier Guidelines

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Description

According to the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS), a modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

Modifiers may be used to indicate that:

- A service or procedure has a professional or technical component.
- A bilateral procedure was performed.
- A service was distinct or separate.
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure has been increased or reduced.
- An add-on or additional service was performed.
- A service or procedure was provided more than once.
- A service or procedure was performed on a specific site.
- Only part of a service was performed.
- Unusual events occurred.

Certain modifiers are used for informational purposes only and do not affect reimbursement.

Policy

Oscar utilizes modifiers in determining reimbursement eligibility. When services are billed with inappropriate modifiers or the lack of an appropriate modifier according to our policy, it will not be eligible for reimbursement.

Reimbursement for a procedure code/modifier combination will be considered only when the modifier has been used appropriately in accordance with correct coding principles defined ICD-10, HCPCS and CPT.

Reimbursement Guidelines

Common modifiers, descriptions, and details are outlined below. This is not a comprehensive list of all modifiers defined within the CPT and HCPCS code sets. Therefore, the absence of a modifier from this list does not indicate that it is not recognized by Oscar.

Modifiers Defined by CPT® Appendix A

Modifier	Description	Details
22	Increased Procedural Services	Indicates that a service or procedure required increased intensity or effort.
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period	Designates that an unrelated E&M was performed beginning the day after and within the postoperative period of an unrelated 10-day or 90-day global procedure. See “Evaluation and Management Services” Reimbursement Policy.
25	Significant, Separately Identifiable Evaluation and Management Service by the Same	Designates that a separately identifiable E&M service was performed on the same day as another procedure.

	Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service	Modifier 25 is only applicable on professional claims. See “Evaluation and Management Services” Reimbursement Policy.
26	Professional Component	When the physician’s component is separately reportable, the service may be identified by appending modifier -26 to the procedure code. **Note** Oscar denies “Incident To” codes identified with a CMS PC/TC indicator 5 in the NPFS when reported in a facility place of service when billed by a physician. Modifiers -26 and TC cannot be used with these codes. Oscar does not reimburse codes identified by CMS as having no professional component (PC/TC Indicator of 3,4, or 9) when billed with a -26 modifier.
47	Anesthesia by Surgeon	No additional benefits are allowed above the total allowed for the surgical procedure if the anesthesia services are not administered by, or under the supervision of, a doctor other than the attending surgeon or assistant surgeon.
50	Bilateral Procedure	Use of the 50 modifier will not result in additional reimbursement when used with procedures which cannot be performed bilaterally or for which the base CPT code signifies a bilateral procedure. See “Bilateral Procedures” Reimbursement Policy.
51	Multiple Procedures	Designates multiple procedures that are performed at the same session by the same provider, other than evaluation and management services, physical medicine and rehabilitation services, or provision of supplies. **Note:** This modifier is not appropriate to append to evaluation and management services. This modifier is not to be appended to designated “add-on” codes. See “Multiple Procedures” Reimbursement Policy.
52	Reduced Services	Indicates that a service or procedure has been partially reduced or eliminated at the physician’s discretion.
53	Discontinued Procedure	Indicates a procedure was started but discontinued. Modifier 53 is not appropriate for use with: ● Facility billing ● Evaluation and management (E/M) services ● Elective cancellation of a service prior to anesthesia induction and/or surgical preparation in the operating suite. ● Laboratory panel code
54	Surgical Care Only	Indicates when a physician or other qualified healthcare professional furnishes only part of a global surgical package and relinquishes the other portion(s) of the surgical package to another physician or other qualified healthcare professional. Modifiers 54, 55, and 56 are appended to the surgical procedure code and only apply to services with a 10- or 90-day global period.
55	Postoperative Management Only	
56	Preoperative Management Only	
57	Decision for Surgery	Appended when an evaluation and management service that results in the initial decision to perform surgery. It is intended to report that the decision to perform major surgery occurred on the day of or day prior to, a major (90-day global) surgical procedure. See “Evaluation and Management Services” Reimbursement Policy.

58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	Designates a staged or related procedure performed during the postoperative period of the first procedure by the same physician. Modifier 58 is to be reported with the applicable code for the staged procedure. Modifier 58 is not applicable to unrelated procedures during the postoperative period, assistant surgeon claims, or when the initial procedure does not carry a global period.
59	Distinct Procedural Service	Indicates when a procedure is distinct or independent from another non-evaluation and management service performed on the same day. **Note:** The Centers for Medicare & Medicaid Services (CMS) has established four HCPCS modifiers to define subsets of modifier 59. These modifiers function in the same manner as modifier 59. Since the HCPCS modifiers are more detailed descriptions of modifier 59, it would be incorrect to include both on the same claim line according to CMS. Therefore, any code appended with 59 in addition to XE, XP, XS, or XU will not be eligible for reimbursement.
62	Two Surgeons	Indicates that services were performed by two surgeons, and will be reimbursed according to our “Multiple Surgeons Reimbursement Policy”.
66	Surgical Team	Indicates that services were performed by a surgical team, and will be reimbursed according to our “Multiple Surgeons Reimbursement Policy”.
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia	Appended to indicate that the procedure was discontinued prior to completion. This modifier is not applicable for professional provider billing.
74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia	
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional	Indicates that a procedure or service was repeated subsequent to the original procedure or service by the same provider on the same patient on the same date of service or within the post-operative period.
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional	Indicates the same procedure or service has been performed by a different provider to the same patient on the same date of service or within the post-operative period of the original procedure.
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period	In order for a procedure code billed with modifier 78 or 79 to be eligible for reimbursement, Oscar must have evidence that a procedure was billed on the same date of service or within the postoperative period as defined by the 0, 10, or 90 day postoperative period definition.
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	
80	Assistant Surgeon	Indicates that services were performed by an assistant surgeon, and will be reimbursed according to our “Multiple Surgeons Reimbursement Policy”.
81	Minimum Assistant Surgeon	
82	Assistant Surgeon (when qualified resident surgeon not available)	

90	Reference (Outside) Laboratory	Represents a reference (outside) laboratory and will only be eligible for reimbursement if billed by a provider with a specialty designation of Laboratory or Pathology.
91	Repeat Clinical Diagnostic Laboratory Test	Used to report repeat laboratory tests on the same date of service to obtain multiple test results. Modifier 91 should not be used when tests are repeated to confirm initial test results due to testing problems with equipment or specimens or with codes that describe a series of test results, such as glucose tolerance or evocative suppression tests.
92	Alternative Laboratory Platform Testing	Used for alternative laboratory platform testing. Only HIV testing will be eligible for reimbursement when billed. All other codes containing this modifier will not be eligible for reimbursement.
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System	Used to designate when a service is a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified healthcare professional. See “Services Delivered via Telemedicine” Reimbursement Policy.
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System	Used to designate when a service is a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified healthcare professional. See “Services Delivered via Telemedicine” Reimbursement Policy.

Level II HCPCS/National Modifiers

Modifier	Description	Details
AA	Anesthesia services performed personally by anesthesiologist	Physicians must report appropriate anesthesia modifiers with general anesthesia services to denote whether the service was personally performed, medically directed, medically supervised, or represented by monitored anesthesia care. Also, services rendered by CRNAs must report the appropriate anesthesia modifier to indicate whether the service was performed with or without medical direction by a physician. Appropriate modifiers for anesthesia services are: AA, AD, GC, QK, QX, QY, and QZ. General anesthesia services (CPT 00100-01969) will be denied if billed without an appropriate modifier. Anesthesia modifiers should only be appended to anesthesia services. Additional service modifiers may be appropriate to use for anesthesia services, however when inappropriate service modifiers are appended to an anesthesia code, that service will not be eligible for reimbursement. See also reimbursement policy titled, “Anesthesia”.
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	This modifier designates that services were provided by a physician assistant, nurse practitioner or nurse midwife for an assistant at surgery. Please refer to our “Multiple Surgeons” Reimbursement Policy.
AT	Acute Treatment	Used in conjunction with chiropractic manipulative treatment CPT Codes 98940-98942 to designate acute treatment. Modifier AT designates active/corrective treatment to treat acute or chronic subluxation and is not to be used for maintenance therapy.
E1 - E4	Eyelid Modifiers: ● E1 - Upper left, eyelid ● E2 - Lower left, eyelid ● E3 - Upper right, eyelid ● E4 - Lower right, eyelid	Anatomic Modifier - Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims.

FA - F9	Finger Modifiers: ● FA - Left hand, thumb ● F1 - Left hand, second digit ● F2 - Left hand, third digit ● F3 - Left hand, fourth digit ● F4 - Left hand, fifth digit ● F5 - Right hand, thumb ● F6 - Right hand, second digit ● F7 - Right hand, third digit ● F8 - Right hand, fourth digit ● F9 - Right hand, fifth digit	Anatomic Modifier - Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims.
FS	Split (or shared) evaluation and management visit	Used to designate an E&M service that was performed in part by a physician and in part by other nonphysician practitioners in a facility setting. See “Evaluation and Management Services” Reimbursement Policy.
GC	This service has been performed in part by a resident under the direction of a teaching physician	Appended to a service that has been completed by a resident in a teaching facility in part under direction and supervision of a teaching physician.
GG	Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day	Consistent with CMS policy, specific modifiers are required when both a screening and diagnostic mammogram are performed on the same date of service. In this scenario, the diagnostic mammogram must be appended with Modifier GG in order to be eligible for reimbursement. Similarly, the screening mammogram must also be appended with Modifier 59, XE, XP, or XU otherwise, the screening mammogram will not be eligible for reimbursement.
GN	Services delivered under an outpatient speech language pathology plan of care	Oscar will require certain codes that are designated by CMS as “always therapy” to be filed with the appropriate modifier (GP, GO, or GN). This allows correct payment when they are performed under the physical therapy, occupational therapy, or speech-language pathology plan of care.
GO	Services delivered under an outpatient occupational therapy plan of care	
GP	Services delivered under an outpatient physical therapy plan of care	
GQ	Via asynchronous telecommunications system	Used to designate when a service is an asynchronous interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified healthcare professional. See “Services Delivered via Telemedicine” Reimbursement Policy.
GT	Via interactive audio and video telecommunication systems	Used to designate when a service is a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified healthcare professional. See “Services Delivered via Telemedicine” Reimbursement Policy.
JW	Drug amount discarded/not administered to any patient	Used to designate when a portion of a single-dose vial or package was discarded. Should be reported with two lines: one with the drug code and modifier JW for the discarded amount and one with the same drug code without modifier JW for the administered amount. Modifier JW is not to be reported with a multi-dose vial or package or in conjunction with modifier JZ.
JZ	Zero drug amount discarded/not	Used to designate when the entirety of a single-dose vial or package was administered.

	administered to any patient	Modifier JZ is not to be reported with a multi-dose vial or package or in conjunction with modifier JW.
LC	Left Circumflex Coronary Artery	Anatomic Modifier - Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims.
LD	Left Anterior Descending Coronary Artery	
LM	Left Main Coronary Artery	
LT	Left Side (used to identify procedures performed on the left side of the body)	Anatomic Modifier - Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims.
PA	Surgical or other invasive procedure on wrong body part	Indicates Never Events and are not considered reimbursable services. See “Never Events” Reimbursement Policy.
PB	Surgical or other invasive procedure on wrong patient	
PC	Wrong surgery or other invasive procedure on patient	
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	Oscar requires PET scans to be billed with a PI or a PS modifier to be considered reimbursable. See “Radiology” Reimbursement Policy.
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 antitumor strategy	
QW	CLIA waived test	Indicates a Clinical Laboratory Improvement Amendment (CLIA) waived test and the possession of a CLIA certificate that allows the performance and reporting of CLIA-waived tests.
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	Physicians must report appropriate anesthesia modifiers with general anesthesia services to denote whether the service was personally performed, medically directed, medically supervised, or represented by monitored anesthesia care. Also, services rendered by CRNAs must report the appropriate anesthesia modifier to indicate whether the service was performed with or without medical direction by a physician. Appropriate modifiers for anesthesia services are: AA, AD, GC, QK, QX, QY, and QZ. General anesthesia services (CPT 00100-01969)* will be denied if billed without an appropriate modifier. Anesthesia modifiers should only be appended to anesthesia services. Additional service modifiers may be appropriate to use for anesthesia services, however when inappropriate service modifiers are appended to an anesthesia code, that service will not be eligible for reimbursement. See also reimbursement policy titled, “Anesthesia”.
QX	CRNA service: with medical direction by a physician	
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist	
QZ	CRNA service: without medical direction by a physician	

RC	Right Coronary Artery	Anatomic Modifier - Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims.
RI	Ramus Intermedius Coronary Artery	
RR	Rental (use the RR modifier when DME is to be rented)	Capped rental DME must be appended with Modifier RR.
RT	Right Side (used to identify procedures performed on the right side of the body)	Anatomic Modifier - Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims.
SL	State supplied vaccine	Vaccines and toxoids provided at no cost by the state are not eligible for reimbursement. See also reimbursement policy titled, “Immunization Guidelines”.
SS	Home infusion services provided in the infusion suite of the IV therapy provider	Used with the codes for home infusion therapy including infusion, injection and other administrations to indicate the administration was provided in the ambulatory infusion suite of the home infusion therapy provider.
TA - T9	Toe Modifiers: ● TA - Left foot, great toe ● T1 - Left foot, second digit ● T2 - Left foot, third digit ● T3 - Left foot, fourth digit ● T4 - Left foot, fifth digit ● T5 - Right foot, great toe ● T6 - Right foot, second digit ● T7 - Right foot, third digit ● T8 - Right foot, fourth digit ● T9 - Right foot, fifth digit	Anatomic Modifier - Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims.
TC	Technical Component	Designates the technical component of a service. When the technical component is separately reportable, the service may be identified by appending modifier TC to the procedure code. ****Note**: Oscar does not reimburse technical component services billed separately from the facility claim when performed in a facility place of service.
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter	Modifiers XE, XP, XS, and XU should be used instead of modifier 59 when the modifier appropriately describes the service. According to CMS, these modifiers are a more detailed description of modifier 59 and it would be incorrect to include both on the same claim line. Therefore, any code appended with 59 in addition to XE, XP, XS, or XU will not be eligible for reimbursement.
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner	
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure	
XU	Unusual nonoverlapping service, the use of a service that is distinct because it does not overlap usual components of the main service	

Additional Modifier Considerations

Modifier Use in Fracture Care - When a fracture or dislocation care code is billed in the office setting and the same code has been billed by any provider in the past 10 days, it is assumed that the second billing of this code is duplicative, and it will be denied. When a fracture care code is billed in the office setting that is different from another fracture care code that was billed in the previous 2 weeks, it is assumed that the second code was inappropriately coded and that it also represents post-operative care for the earlier service. In this situation, the second code will be denied. An exception exists for procedures billed with an appropriate modifier which designates that the services are unrelated. The modifiers are listed below:

- 54 (surgical care only)
- 55 (Post-operative management only)
- 76 (Repeat procedure by same physician)
- 77 (Repeat procedure by another physician)
- 78 (Return to operating room for a related procedure during the postoperative period)
- 79 (Unrelated procedure or service by same physician during the postoperative period)

Note: Modifier 54 is not appropriate to use with fracture care codes for closed treatment without manipulation in the emergency department.

Deceased Modifier Services - Supplies and/or devices are not reimbursable if modifier **CA**, **PM**, **P6** or **QL** have been reported on a prior date of service.

Related Policies (if applicable)

Anesthesia
Bilateral Procedures
Evaluation and Management Services
Immunization Guidelines
Multiple Procedures
Multiple Surgeons
Radiology
Services Delivered via Telemedicine

References

1. Centers for Medicare & Medicaid Services, CMS Manual System, and Medicare Claims Processing Manual 100-04
2. American Medical Association, Current Procedural Terminology (CPT®)
3. Healthcare Common Procedure Coding System (HCPCS)

Publication History

Date	Action/Description
02/27/2024	New Policy Development. Reimbursement Governance Committee Approved.
03/27/2025	Annual Review. Reformatted modifier details into a table for easier reference; Added modifiers; Removed statement from rationale section as it was redundant with policy section; Relocated statement from coding section into policy section.