CPT and HCPCS Level II Modifiers[1]

The presence or absence of one of the following modifiers may affect claims payment or result in a claim denial. For a complete list of modifiers, refer to your CPT and HCPCS coding guideline manuals.

Harvard Pilgrim accepts up to four modifiers per line.

Modifier	Description	Reimbursement Impact
22	Unusual procedural services	• Antepartum E&M visits due to pregnancy complications that exceed the typical care (14 visits) will be given individual consideration when modifier is appended to the global obstetrical codes (CPT codes 59400, 59510, 59610 or 59618) and supported by the medical documentation. • For other services after appropriate use of modifier is validated, 120% of the fee schedule/allowable amount.
23	Unusual anesthesia	Modifier use will not impact reimbursement
24	Unrelated evaluation and management service by the same physician during a postoperative period	Modifier use will not impact reimbursement
25	Significant, separately identifiable E&M service by the same physician on the same day of the procedure or service	See Evaluation & Management Policy for specific details
26	Professional component	Used for procedures subject to 26 modifier as defined by CMS. Based on fee schedule/allowable amount
27	Multiple outpatient hospital E&M encounters on the same date	Modifier use will not impact reimbursement
32	Mandated services	Modifier use will not impact reimbursement
47	Anesthesia by surgeons	No additional reimbursement is allowed for anesthesia by a surgeon, assistant surgeon, nursing staff or any other non-anesthesiologist professional during a procedure
50	Bilateral procedure (see Bilateral Services Policy)	Refer to the General Coding and Claims Editing Payment Policy for billing directives
51	Multiple procedures	Primary procedure is reimbursed at 100% of the fee schedule/allowable, subsequent procedures are reimbursed at 50% of the fee schedule/allowable amount
52	Reduced services	Reimbursed at 50% of the fee schedule/allowable amount
53	Discontinued procedure	Reimbursed at 25% of the fee schedule/allowable amount
54	Surgical care only	Reimbursed at 80% of the fee schedule/allowable amount

Modifier	Description	Reimbursement Impact
55	Postoperative management only	Reimbursed at 10% of the fee schedule/allowable amount
56	Preoperative management only	Reimbursed at 10% of the fee schedule/allowable amount
57	Decision for surgery	Modifier use will not impact reimbursement
58	Staged or related procedure or service by the same physician during postoperative period	Modifier use will not impact reimbursement
59	Distinct procedural service XE-Separate Encounter XP-Separate Practitioner XS-Separate Organ/Structure XU-Unusual Separate Service	After appropriate use of modifier is validated, claims submitted with operative/medical notes will be reviewed to determine whether procedure code is distinct or independent from other services: – First time claim submissions can be submitted on paper with operative notes for consideration (This is not applicable to all claim types.) – Denied claims may be appealed with operative notes for consideration
62	Two surgeons	Reimbursed at 62.5% of the fee schedule/allowable amount
63	Procedure performed on infants less than 4 kg.	Modifier use will not impact reimbursement
66	Surgical team	Harvard Pilgrim will make a determination regarding reimbursement after individual consideration and review of operative notes
73	Discontinued outpatient procedure prior to anesthesia administration	Reimbursed at 50% of the fee schedule/allowable amount
74	Discontinued outpatient procedure after anesthesia administration	Reimbursed at 70% of the fee schedule/allowable amount
76	Repeat procedure by same physician	Modifier use will not impact reimbursement
77	Repeat procedure by another physician	Modifier use will not impact reimbursement
78	Return to the operating room for a related procedure during the postoperative period	Prior to dates of service January 1, 2023, reimbursed at 80% of the fee schedule/allowable amount. As of dates of service on or after January 1, 2023, reimbursed at 70% of the fee schedule/allowable amount.
79	Unrelated procedures or service by the same physician during the postoperative period	Modifier use will not impact reimbursement
80	Assistant surgeon	Reimbursed at 16% of the fee schedule/allowable amount
81	Minimum assistant surgeon	Reimbursed at 16% of the fee schedule/allowable amount
82	Assistant surgeon (when qualified resident surgeon not available)	Reimbursed at 16% of the fee schedule/allowable amount
90	Reference (outside) laboratory	Modifier use will not impact reimbursement
91	Repeat clinical diagnostic laboratory test	Modifier use will not impact reimbursement

Modifier	Description	Reimbursement Impact
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System: Synchronous telemedicine service is defined as 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 health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Modifier 95 may only be appended to the services listed in Appendix P. Appendix P is the list of CPT codes for services that are typically performed face-to-face but may be rendered via a real-time (synchronous) interactive audio and video telecommunications system.	Prior to dates of service February 28, 2023, modifier use will not impact reimbursement. Effective for dates of service on or after March 1, 2023, applicable services are reimbursed at 80% of the fee schedule/allowable amount.
AS	Physician assistant, nurse practitioner or clinical nurse specialist services for assistant at surgery	Reimbursed at 14% of the applicable fee schedule/ allowable rate
GT	Via interactive audio and video telecommunications system	Prior to dates of service February 28, 2023, modifier use will not impact reimbursement. Effective for dates of service on or after March 1, 2023, applicable services are reimbursed at 80% of the fee schedule/allowable amount.
TC	Technical component	For procedures subject to TC modifier as defined by CMS

Common Modifiers for Anesthesia Claims

Harvard Pilgrim requires the use of the following modifiers as appropriate for claims submitted by anesthesiologists when reporting anesthesia services.

Modifier	Description	Reimbursement Impact
AA	Anesthesia services performed personally by anesthesiologist	Allows 100% of fee schedule/allowable rate
AD	Medical supervision by a physician; more than four concurrent anesthesia procedures	Reimbursed at 100% of Harvard Pilgrim anesthesia rate (three base units) plus one additional unit if the physician was present for intubation.
GC	Services performed in part by a resident under the direction of a teaching physician; services are not reimbursable to a resident	Modifier use will not impact reimbursement
QZ	CRNA service: without medical direction by a physician	Reimbursed at 100% of Harvard Pilgrim anesthesia rate
QY	Medical direction of one certified registered nurse Anesthetist by an anesthesiologist	Allows 50% of fee schedule/allowable rate

Modifier	Description	Reimbursement Impact
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	Allows 50% of fee schedule/allowable rate
QX	CRNA service: with medical direction by a physician	Allows 50% of fee schedule/allowable rate
QS	Monitored anesthesia care (MAC) provided by an anesthesiologist	Modifier use will not impact fee schedule reimbursement
P1–P6	Anesthesia Physical Status Modifiers	These modifiers are required and should be reported in the secondary modifier position; these modifiers will not impact reimbursement.

HCPCS Modifiers

Anatomical modifiers are required to designate the area or part of the body on which the procedure is performed on different sites during the same session.

Modifier Category	Modifier	Modifier Description
Common Site-Specific Modifiers	E1–E4	Eyelids
	FA–F9	Fingers
	TA–T9	Toes
	RT	Right
	LT	Left
	LC	Left circumflex, coronary artery
	LD	Left anterior descending coronary artery
	LM	Left main coronary artery
	RI	Ramus intermedius
	RC	Right coronary artery
Common DME Modifiers	AU	Required when billing A4450, A4452, or A5120
	AV	Required when billing A4450, A4452, or A5120
	AW	Required when billing A4450 or A4452
	A1-A9	Required when billing A4450 or A4452
	K0-K4	Functional modifiers to be reported with lower limb prosthetics
	NU	Purchased new equipment
	MS	Maintenance and service fee
	RA	Replacement of a DME, orthotic or prosthetic item
	RR	Rental use
Common Early Intervention Modifiers	AH	Clinical psychologist
	AJ	Clinical social worker
	GN	Outpatient speech language

Modifier Category	Modifier	Modifier Description
	GO	Outpatient occupational therapy
	GP	Outpatient physical therapy
	HN	Bachelor's degree level
	TD	Registered nurse (RN)
	TE	Licensed practical nurse (LPN)
	TF	Intermediate level of care – applicable only to Connecticut Birth to Three contracted providers
	TJ	Program group child
	TM	Individualized education program Effective for dates of service on or after July 1,2023, reimbursement will not be provided.
	TR	School-based individualized education program services provided outside the public school district responsible for the student Effective for dates of service on or after July 1,2023, reimbursement will not be provided.
	U1	Medicaid level of care 1 (defined by each state)
	U2	Medicaid level of care 2 (defined by each state)
Common Ambulance Modifiers	GM	Multiple patients on one trip
	QM	Ambulance service provided under arrangement by a provider of services
	QN	Ambulance service furnished directly by a provider of services
	D	Diagnostic or therapeutic site other than P or H, when these are used as origin codes
	E	Residential, domiciliary, custodial facility (other than 1819 facility)
	G	Hospital based dialysis facility (hospital or hospital related)
	H	Hospital
	I	Site of transfer (e.g., airport or helicopter pad)
	J	Non-hospital-based dialysis facility
	N	Skilled nursing facility (SNF)
	P	Physician's office
	R	Residence
	S	Scene of accident or acute event
	X	Destination code only — intermediate stop at physician's office on the way to the hospital

Modifier Category	Modifier	Modifier Description
Physical and Occupational Therapy Modifiers	CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
	CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
	GP	Services delivered under an outpatient physical therapy plan of care
	GO	Services delivered under an outpatient occupational therapy plan of care
Other Miscellaneous Modifiers	SL	State-supplied vaccine
	PM	Postmortem
	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
	FX	X-ray taken using film
	GT	Via interactive audio and video telecommunication systems
	PN	Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital
	PO	Services, procedures and/or surgeries performed at off-campus provider-based outpatient departments — facility only
	SG	Ambulatory Surgical Center (ASC) facility service
	V1	Demonstration modifier 1
	V2	Demonstration modifier 2
	V3	Demonstration modifier 3

Related Policies

Payment Policies

- Ambulance Transport
- Anesthesia
- Durable Medical Equipment (DME)
- Early Intervention
- Evaluation and Management
- General Coding and Claims Editing
- Obstetrical/Maternity Care
- Oral Surgery
- Outpatient Facility Fee Schedule
- Physical, Occupational, and Speech Therapy
- Radiology
- Surgery
- Telehealth/Telemedicine

Clinical Policies

- Monitored Anesthesia Care for Gastrointestinal Endoscopic Procedures

PUBLICATION HISTORY

7/01/04	original documentation
07/01/05	policy update to modifiers 24 and 59
07/31/07	annual review
01/31/08	annual review; added multiple modifier information
07/31/08	policy update to bilateral procedure
01/31/09	annual coding update; removed mod 21
03/15/09	update to modifiers 78, 80, 81, 82, and AS
05/15/09	annual review: HCPC modifier tables updated, minor edit to modifier 59; added “Related Policies”
10/15/09	update to modifier 52
01/15/10	update to modifier 53, clarification of reimbursement impact for claims submitted with multiple modifiers
06/15/10	annual review; no changes
10/15/10	modifier 25 update — E&M’s with surgery/diagnostic procedure
11/15/10	modifier 25 minor edits for clarity
04/15/11	minor edits for clarity
06/15/11	annual review; added GO/GP modifiers
10/15/11	policy update to modifier 22, antepartum E&M visits due to complications will be given individual consideration; added Obstetrical/Maternity Care to related policies
01/01/12	removed First Seniority Freedom information from header
07/15/12	annual review; no changes
05/15/13	annual review: minor edits for clarity
01/1514	annual coding update; added new modifier ‘PM’ to coding grid
06/15/14	annual review, administrative edits
02/15/15	annual coding update
11/15/15	annual review; added RA modifier
01/15/16	annual coding update
09/15/16	added HPHC requires the use of anesthesia modifiers, added related medical policy
11/15/16	annual review; added modifiers GT and SZ
01/15/17	annual coding update
04/15/17	added anatomical modifiers are required as of 06/15/17
06/15/17	update to modifiers GT and 95
11/15/17	annual review; no changes
02/01/18	annual coding update
12/03/18	annual review; updated chart with modifiers SG, TF, and DME modifiers; added related policy
02/01/19	annual coding update
06/03/19	added reimbursement change to modifier AS
12/02/19	annual review; no changes
12/01/20	annual review; administrative edits
03/01/20	revised comments for AA, QY, QK and QX modifiers
12/01/21	annual review; administrative edits
11/01/22	annual review; updated reimbursement rate for modifier 78 as of 1/1/23, clarified reimbursement impact for modifier AD, added Anesthesia Payment Policy to related policies, minor edits for clarity, administrative edits
08/01/23	added modifiers TM and TR are not reimbursed as of dates of service 7/1/23
09/01/23	added related payment policy, modifier 95 and GT decrement as of dates of service 3/1/23
12/01/23	annual review; administrative edits

[1]This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England, and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.