

Code Modifiers

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Review dates: None yet recorded

DEFINITION

Claims should be coded accurately for the first time to support timely payment and avoid appeals. Modifiers add detail to a procedure code without changing its meaning and are defined in CPT and HCPCS. If a claim is denied due to incorrect coding, submit a corrected claim. Do not file an appeal for coding errors.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD, or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD [in our Provider Manual](#).

POLICY SPECIFIC INFORMATION

Effective May 1, 2024, appeals submitted for incorrectly coded claims will be denied, as denials will be upheld. Providers have only one opportunity to appeal per claim. Guidance is available to support the correct use of commonly misused modifiers.

Place of service

This policy applies to all applicable places of service, unless otherwise noted. Modifier use must be consistent with the setting where the service is performed and follow established billing guidelines.

Documentation requirements

Medical records must clearly support the use of any modifier applied to a code. Failure to provide sufficient documentation may result in a claim denial or a request for additional information.

Coding specifics

Modifiers should only be applied to CPT and HCPCS codes when they correctly describe the circumstances of the service provided. Using modifiers appropriately helps ensure accurate claim processing and proper reimbursement.

Modifiers

Modifier	Modifier description	Reference links
22	Unusual procedural services	Modifier 22, unusual procedural services Anesthesia modifiers
23	Unusual Anesthesia	Anesthesia modifiers
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care	Modifier 24, Unrelat E/M service

	Professional During a Postoperative Period	
25	Significant, Separately Identified Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service	Modifier 25, separate E&M service, same physician, same day
26 & TC	Professional or Technical component	Modifiers 26 and TC, professional or technical component only
27	Multiple Outpatient Hospital E/M Encounters on the Same Day	Modifier 27 in facility coding
32	Mandated Services	Anesthesia modifiers
33	Preventive Services	Modifier 33, preventive service
47	Anesthesia by Surgeon	Anesthesia modifiers
50 & 51	Bilateral & Multiple Procedures	Modifiers 50 & 51, bilateral vs. multiple procedures
52	Reduced Services	Modifier 52, reduced services
53	Discontinued Procedure	Modifier 53, discontinued procedure Anesthesia modifiers
54 & 55	Surgical Care	Modifiers 54 and 55, co-management of surgery/post-op care
56	Preoperative Management Only	Modifier 56, pre-operative management only
57	Decision for Surgery	Modifier 57
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	
59	Distinct Procedural Service	Modifiers 59, XE, XS, XP & XU, separate or distinct services Anesthesia modifiers
62	Two Surgeons	Modifiers 62 and 66, multiple surgeons
63	Procedure Performed on Infants Less Than 4 kg	
66	Surgical Team	Modifiers 62 and 66, multiple surgeons
73 & 74	Outpatient procedure	Modifiers 73 & 74, outpatient procedure discontinued
76 & 77	Repeat Procedures	Modifiers 76 and 77, repeated procedure(s)

78	Unplanned Return to Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a related Procedure During the Postoperative Period	Modifier 78, unplanned return to the operating room Anesthesia modifiers
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	
80, 81, 82	Assistant Surgery	Modifiers 80, 81, 82, assistant at surgery
90	Reference (Outside) Laboratory	
91	Repeat Clinical Diagnostic Laboratory Test	
92	Alternative Laboratory Platform Testing	
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System	
99	Multiple Modifiers	Anatomic Modifiers / Modifier 99 – Multiple modifiers
A1	Dressing for one wound	
AA	Anesthesia services performed personally by anesthesiologist	Anesthesia modifiers - HCPCS Level II modifiers
AB	Audiology service furnished personally by an audiologist without a physician/ NPP order for nonacute 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	
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	Anesthesia modifiers - HCPCS Level II modifiers
AI	Principal physician of record	AI: Principal physician of record modifier
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	

AT	Acute treatment (this modifier should be used when reporting service 98940, 98941, 98942)	AT: Active treatment modifier
AY	Item or service furnished to an ESRD patient that is not for the treatment of ESRD	
CR	Catastrophe/disaster related	
CT	Computed tomography services furnished using equipment that does not meet each of the attributes of the national electrical manufacturer's association (NEMA) XR-29-2013 standard	
E1, E2, E3, E4	Eye lid	Anatomic Modifiers - Eye lid modifiers
FA, F1, F2, F3, F4, F5, F6, F7, F8, F9	Finger/ digit hand	Anatomic Modifiers - finger/digit of hand modifiers
FS	Split (or shared) evaluation and management 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)	Modifier FT: Unrelated critical care services
FX	X-ray taken using film	
FY	X-ray taken using computed radiography technology/cassette-based imaging	
G0	Telehealth services for diagnosis, evaluation, or treatment of symptoms of an acute stroke	
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure	Anesthesia modifiers
G9	Monitored anesthesia care for patient who has history of severe cardiopulmonary condition	Anesthesia modifiers

GA, GY, GZ	Pre-Service / Service not covered	Modifiers GA, GY and GZ, Medicare non-coverage
GC	This service has been performed in part by a resident under the direction of a teaching physician	Anesthesia modifiers - HCPCS Level II modifiers
GE	This service has been performed by a resident without the presence of a teaching physician under the primary care exception	
GJ	"Opt out" physician or practitioner, emergency or urgent service	
GN, GO, GP	Therapy Codes	Modifiers GN, GO and GP, outpatient therapy plans of care
GQ	Via asynchronous telecommunications system	
GT	Via interactive audio and video telecommunication systems	
GV	Attending physician not employed or paid under arrangement by the patient's hospice provider	
GW	Service not related to the hospice patient's terminal condition	
H9	Court-ordered	
HU	Funded by child welfare agency	
HV	Funded by state addictions agency	
HW	Funded by state mental health agency	
HX	Funded by county/local agency	
HY	Funded by juvenile justice agency	
HZ	Funded by criminal justice agency	
JA, JB	Administration	JA, JB: Route of administration modifiers
JW, JZ	Drug dosing	JW, JZ: Drug dosing modifiers
KX	Requirements specified in the medical policy have been met	
LC, LD, LM, RC, RI	Coronary artery modifiers	Anatomic Modifiers/ Coronary artery modifiers
LT, RT	Laterality side of body	Anatomic Modifiers - Laterality (side of body) modifiers
N1	Group 1 oxygen coverage criteria	

N2	Group 2 oxygen coverage criteria met	
N3	Group 3 oxygen coverage criteria met	
P1, P2, P3, P4, P5, P6	Physical status	Anesthesia modifiers - Physical status modifiers (PS)
PA, PB, PC	Preventable conditions	PA, PB, PC: Preventable conditions modifiers
PD	Diagnostic or related nondiagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days	
PO	Excepted service provided at an off-campus, outpatient, provider-based department of a hospital	
PT	Colorectal cancer screening test; converted to diagnostic test or other procedure	
Q0	Investigational clinical service provided in a clinical research study that is in an approved clinical research study	
Q1	Routine clinical service provided in a clinical research study that is in an approved clinical research study	
QB	Physician provided service in a rural HPSA	Anesthesia modifiers - HCPCS Level II 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 T4CFR 411.4(B)	
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	Anesthesia modifiers - HCPCS Level II modifiers
QS	Monitored anesthesiology care service	Anesthesia modifiers - HCPCS Level II modifiers
QX	CRNA service: with medical direction by a physician	Anesthesia modifiers - HCPCS Level II modifiers
QY	Medical direction of one certified reg	Anesthesia modifiers - HCPCS Level II modifiers

QZ	CRNA service: without medical direction by a physician	Anesthesia modifiers - HCPCS Level II modifiers
SA	Nurse practitioner rendering service in collaboration with a physician	
SE	State and/or federally funded program/services	
SG	Ambulatory surgical center (ASC) facility service	
SL	State supplied vaccine	
SU	Procedure performed in physician's office (to denote use of facility and equipment)	
TA, T1, T2, T3, T4, T5, T6, T7, T8, T9	Toe/ digit of foot	Anatomic Modifiers - Toe/digit of foot modifiers
TB	Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes	
TR	School-based individualized education program (IEP) services provided outside the public school district responsible for the student	
UA, UD	Treated and released or admitted/ transferred	Modifiers UD, UA, treated and released or admitted/transferred
UN	Two patients served	
UP	Three patients served	
UQ	Four patients served	
UR	Five patients served	
US	Six or more patients served	
XE, XS, XP, XU	Separate or distinct services	Modifiers 59, XE, XS,XP & XU, separate or distinct services

Resources

- [Using code modifiers](#)

Related policies

- [Facility Modifiers](#)
- [JA, JB: Route of administration modifiers](#)

Related denial language

Include any denial language here

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies, and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis, and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available [in our Provider Manual](#).

CHANGE / REVIEW HISTORY

Date	Revisions made
May 2026	New Policy