Modifiers

Modifiers indicate that a service or procedure performed has been altered by some specific circumstance, but not changed in its definition or code. They are used to add information or change the description of service to improve accuracy or specificity. Modifiers can be alphabetic, numeric or a combination of both, but will always be two digits.

Part B providers: Try our new modifier lookup tool - Find modifier details!

* [Modifier Lookup Tool for JL](https://www.novitas-solutions.com/webcenter/portal/MedicareJL/ModifierLookup) - Part B only
* [Modifier Lookup Tool for JH](https://www.novitas-solutions.com/webcenter/portal/MedicareJH/ModifierLookup) - Part B only

Some modifiers cause automated pricing changes, while others are used for information only. When selecting the appropriate modifier to report on your claim, please ensure that it is valid for the date of service billed.

If more than one modifier is needed, list the payment modifiers—those that affect reimbursement directly—first.

Payment modifiers include: 22, 26, 50, 51, 52, 53, 54, 55, 58, 62, 66, 78, 79, 80, 81, 82, AA, AD, AS, TC, QK, QW, and QY.

Informational or statistical modifiers (e.g., any modifier not classified as a payment modifier) should be listed after the payment modifier.

If multiple informational/statistical modifiers apply, you may list them in any order (as long as they are listed after payment modifiers).

Note: It is up to the provider to determine if a modifier applies, and then choose the most appropriate modifier based on medical documentation.

The definition of each modifier can be found within the document linked in the type of modifier column in the chart below.

For modifiers that can be used for more than one topic, please refer to the [Additional HCPCS](ddocname:00144506) or [other CPT](ddocname:00144515) for definition.

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| --- | --- |
| Type of modifier | Modifiers listed |
| [Additional HCPCS modifiers](ddocname:00144506) | AB, AE, AF, AG, AI, AK, AM, AO, AT, AZ, BL, CA, CB, CG, CR, CS, CT, DA, ER, ET, FB, FC, FS, FX, FY, G7, GC, GE, GG, GJ, GU, J1, J2, J3, JC, JA, JB, JC, JD, JG, JW, JZ, KX, L1, LU, M2, PD, PI, PO, PN, PS, PT, Q0, Q1, Q3, Q4, Q5, Q6, QJ, QQ, RD, RE, SC, SF, SS, SW, TB, TC, TS, UJ, UN, UP, UQ, UR, US, X1, X2, X3, X4, X5, XE, XP, XS, XU |
| [Advance beneficiary notice of noncoverage (ABN) modifiers](ddocname:00144508) | GA, GX, GY, GZ |
| [Advanced diagnostic imaging appropriate use modifiers](ddocname:00219903) | MA, MB, MC, MD, ME, MF, MG, MG, MH, QQ |
| [Ambulance modifiers](ddocname:00144505) | D, E, G, H, I, J, N, P, R, S, X, GM, QL, QM, QN |
| [Anatomical modifiers](ddocname:00144519)  (coronary artery, eye lid, finger, side of body, toe) | E1, E2, E3, E4, FA,F1,F2,F4, F5, F6, F7, F8, F9, LC, LD, LM, LT, RC, RI, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9  Note: If the anatomical modifiers can’t be described by using one of the above modifiers, reference [Proper Use of Modifiers 59 &- X{EPSU}](https://www.cms.gov/files/document/proper-use-modifiers-59-xepsu.pdf). |
| [Anesthesia modifiers](ddocname:00144514) | AA, AD, G8, G9, P1, P2, P3, P4, P5, P6, QK, QS, QY, QX, QZ, 23, 33 |
| [Assistant at surgery modifiers](ddocname:00144530) | AS, 80, 81, 82 |
| [End stage renal disease (ESRD) and Erythropoiesis stimulating agent (ESA) modifiers](ddocname:00144509) | AX, EA, EB, EC, AY, ED, EE, EJ, EM, G1, G2, G3, G4, G5, G6, GS, JA, JB, JE, V5, V6, V7, V8, V9 |
| [Global surgery modifiers](ddocname:00144547) | 24, 25, 54, 55, 57, 58, 78, 79, FT  Note: Modifiers 24, 25, 57 and FT apply to evaluation and management services |
| [Hospice modifiers](ddocname:00144502) | GV, GW |
| [Laboratory modifiers](ddocname:00144504) | 90, 91, 92, LR, QW |
| [Other CPT modifiers](ddocname:00144515) | 26, 27, 33, 59, 76, 77, 96, 97 |
| [Podiatry modifiers](ddocname:00144511) | Q7, Q8, Q9 |
| [Quality reporting incentive programs modifiers](ddocname:00144516) | 1P, 2P, 3P, 8P, AQ, AR, MA, MB, MC, MD, ME, MF, MG, MH, X1, X2, X3, X4, X5 |
| [Surgical modifiers](ddocname:00144542) | 22, 50, 51, 52, 53, 62, 66, 73, 74, PA, PB, PC |
| [Telehealth services modifiers](ddocname:00144501) | 95, FQ, GQ, GT, G0 (zero) |
| [Therapy modifiers](ddocname:00144500) | GN, GO, GP, KX, CO, CQ |

There are times when coding and modifier information issued by CMS differs from the American Medical Association regarding the use of modifiers. A clear understanding of Medicare's rules and regulations is necessary to assign the appropriate modifier.

Examples of when modifiers may be used:

* Identification of professional or technical only components.
* Repeat services by the same or different provider.
* An increased, reduced, or unusual service.
* Billing for components of a global surgical package.
* Identification of a specific body area.
* To designate a bilateral procedure.
* Identification of service in a clinical trial.