Modifiers

Policy

Mass General Brigham Health Plan accepts industry standard modifiers to enable increased accuracy in recording patient encounters. A modifier provides the means by which a provider can report that a service rendered and articulated by a service code has been altered by one or more specific circumstances.

Mass General Brigham Health Plan accepts all standard CPT and HCPCS modifiers in accordance with the appropriate CPT or HCPCS procedure code(s). Certain modifiers, when submitted appropriately, will impact compensation. The absence of an appropriate modifier, or the use of an inappropriate modifier, may result in claim denial.

Reimbursement

Providers are reimbursed according to the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan Payment Policy and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include, but are not limited to, copayments, deductible, and/or co-insurance, and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or authorization. Referral and authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The

absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to Coding Provider Payment Guidelines for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Modifier Tables

The following tables are intended to provide guidance for the proper use of modifiers, and for potential reimbursement impact. Please refer to the AMA CPT and HCPCS manuals for specific guidelines on required and appropriate modifier use.

Ambulance

Report using two modifiers; origin and destination

Modifier	Descriptor
D	Diagnostic/therapeutic site other than “P” or “H”
E	Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)
G	Hospital-based dialysis facility (hospital or hospital related)
GM	Multiple patients on an ambulance trip
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between types of ambulance
J	Non-hospital-based dialysis facility
N	Skilled nursing facility (SNF)
P	Physician’s office (includes HMO nonhospital facility, clinic, etc.)
QM QN	Ambulance service provided under arrangement by a provider of services
R	Residence
S	Scene of accident or acute event

Modifier	Descriptor
X	Intermediate stop at physician's office en-route to hospital (includes HMO non-hospital, facility, clinic, etc.)

Anatomic

Informational; do not impact reimbursement

Modifier	Descriptor
E1-E4	Eyelids
FA, F1-F9	Fingers
TA, T1-T9	Toes
RT	Right side of body
LT	Left side of body
LC, LD, LM, RC, RI	Coronary artery modifiers

Anesthesia

Modifier	Descriptor	Reimbursement Impact/Comments
23	Unusual Anesthesia	• Modifier is informational and does not affect reimbursement
AA	Anesthesia service personally performed by physician	• 100% of anesthesia contract allowable
AD	Medical supervision by a physician for more than 4 concurrent procedures	• 3 ASA base units at anesthesia contract allowable
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified	• 50% of contract allowable
QX	CRNA service with medical direction by a physician	• 50% of contract allowable

Modifier	Descriptor	Reimbursement Impact/Comments
QY	Medical direction of one Certified Registered Nurse Anesthetist by an Anesthesiologist	• 50% of contract allowable
QZ	CRNA service; without medical direction by a physician	• No impact on reimbursement
47	Anesthesia performed by surgeon	• No additional reimbursement for anesthesia by a surgeon, assistant surgeon, nursing staff or any other non-anesthesiologist professional during a procedure
P1-P6	Physical Status Modifiers	• No additional reimbursement

PC (Professional Component)/TC (Technical Component)

Modifier	Descriptor	Reimbursement Impact/Comments
25	Professional Component	• Used by a physician who performs the professional component of a services, which includes supervision and interpretation.
TC	Technical Component	• Used only when the technical component of a service is performed, including equipment, supplies, and staff costs.

Billing tips:

- Before using the 26 or TC modifiers, check to see that the procedure code can accept these modifiers. An indicator of "1" in the PC *(Professional Component)/* TC *(Technical Component)* field on MFSDB *(Medicare Physician Fee Schedule Database)* signifies that Modifiers 26 and TC are valid for the procedure code. Click here to inquire against the Medicare Physician Fee Schedule Data Base
- If the same provider is performing both the technical and professional component of a service,

the global service *(i.e. the procedure code without the TC or 26 Modifier)* should be reported as one claim line and no modifier

- The TC or 26 Modifier should be reported in the first modifier position on the claim

Other

Modifier	Descriptor	Reimbursement Impact/Comments
22	Increased Procedural Services	• Affects reimbursement for surgical codes only • Additional reimbursement considered if the additional work is documented in the operative report submitted to support the use of modifier 22. Cover letters are not considered part of the medical record and cannot be used to support a case for additional reimbursement
24	Unrelated E/M service by same physician during post-op period	• 100% of contract allowable amount only when the service and diagnosis are not related to the surgical procedure • May require medical record review • Visits for complications of surgery that do not require a return trip to the operating room are not to be reported with Modifier 24

Modifier	Descriptor	Reimbursement Impact/Comments
25	Significant, separately identifiable E/M service by same physician on same day of procedure or service	• Clinical notes must support a significant, separately identifiable E/M service above and beyond the services provided • For same day preventive and sick E/M, service with lower valued resource consumption will be reimbursed at 50% of allowable amount. • All claims submitted with this modifier are subject to pre and post-pay audit.
26	Professional Component	• Professional component of allowed amount • Centers for Medicare and Medicaid designate which procedure codes are valid for use with modifier 26.
32	Mandated Services	• Not reimbursed
33	Preventive Service	• Modifier 33 should be appended to the listed CPT/HCPCS codes contained in the U.S. Preventive Services Task Force List which have a category A or category B
50	Bilateral procedure	• 150% of contract allowable • Not for use with codes whose narrative indicates bilateral

Modifier	Descriptor	Reimbursement Impact/Comments
51	Multiple procedure	As of 08/01/2025, MGBHP is updating the Plan's multiple procedure discount rule to align more appropriately with industry standards and CMS. • The primary procedure with the highest Total RVU will be reimbursed at 100% of the allowed amount, unless otherwise specified by the provider's contract • The second lower-Total RVU valued procedure will be reimbursed at 50% of the allowed amount, unless otherwise specified by the provider's contract • The third and greater lower-Total RVU valued procedures will be reimbursed at 25% of the allowed amount, unless otherwise specified by the provider's contract
52	Reduced Services	• 50% of contract allowable
53	Discontinued Procedure	• 25% of fee schedule allowable
54	Surgical care, only	• 85% of fee schedule allowable
55	Post-op management, only	• 15% of contract allowable • Physician performing outpatient post-operative care should report modifier 55 • Surgeon should not report modifier 55 • Dates of service should indicate the range from first date of service to last. The number of units reported should reflect the number of services rendered
56	Pre-op management, only	• 25% of contract allowable
57	Decision for Surgery	• No impact on reimbursement

Modifier	Descriptor	Reimbursement Impact/Comments
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	• No impact on reimbursement
59	Distinct procedural service	• Append Modifier 59{X} to identify procedures and/or services that are distinct and unrelated. Medical record documentation must clearly support the different session and/or procedure, not normally performed on the same day by the same physician and/or group. • Use modifier 59 only when modifier {XESPU} is not appropriate • Modifier 59 should be used only in absence of a more descriptive modifier, and does not alter the reimbursement impact when billed in conjunction with another modifier
XE	Separate encounter	
XS	Separate structure	
XP	Separate practitioner	
XU	Unusual non-overlapping service	
ZB	Pfizer/Hospira	• Required when HCPCS code Q5102.
ZC	Merck/Samsung Bioepis	• Required when HCPCS code Q5102
62	Two Surgeons	• 57.5% of contract allowable • Use Modifier 62 only with qualified service codes as allowed by the CMS National Physician Fee Schedule Relative Value File

Modifier	Descriptor	Reimbursement Impact/Comments
66	Surgical Team	• 62.5% of contract allowable • Medical documentation is required • Use Modifier 66 only with qualified procedures as allowed by the CMS national Physician Fee Relative Value File
73	Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia	• 50% of contract allowable
74	Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia	• 50% of contract allowable
76	Repeat procedure by same physician	• No impact on reimbursement • For repeat, same day laboratory services, use modifier 91
77	Repeat procedure by another physician	• No impact on reimbursement • For repeat, same day laboratory services, use modifier 91
78	Unplanned return to OR for related procedure during post-op period	• 50% of contract allowable
79	Unrelated procedure or service by same physician during postoperative period	• No impact on reimbursement
80	Assistant Surgeon	• 16% of contract allowable • Valid for services designated in the CMS National Relative Value File as qualifying

Modifier	Descriptor	Reimbursement Impact/Comments
81	Minimum Assistant Surgeon	• 16% of contract allowable • Valid for services designated in the CMS National Relative Value File as qualifying
82	Assistant Surgeon (when qualified resident surgeon not available)	• 16% of contract allowable • Valid for services designated in the CMS National Relative Value File as qualifying
90	Reference laboratory	• No impact on reimbursement
91	Repeat clinical diagnostic laboratory test	• No impact on reimbursement • Services must meet medical necessity
92	Alternative laboratory testing	• No impact on reimbursement
95	Synchronous telemedicine Service rendered via a real-time interactive audio and video telecommunications	• Reimbursement is calculated using 50% of the Practice Expense Relative Value Unit (RVU) for the service
96	Habilitative Services	• No impact on reimbursement
97	Rehabilitative Services	• No impact on reimbursement
99	Multiple modifiers	• No impact on reimbursement
AM	Physician billing for PA under direct supervision	• No impact on reimbursement
AS	Physician assistant, nurse practitioner, or clinical nurse specialist as assistant-at- surgery	• 16% of contract allowable
CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant	• No impact on reimbursement
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant	• No impact on reimbursement

Modifier	Descriptor	Reimbursement Impact/Comments
ER	Modifier ER is primarily a billing modifier to help identify items and services furnished by an off-campus, provider-based emergency department	• No impact on reimbursement
G0	Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke	• No impact on reimbursement
GC	This service has been performed in part by a Resident under the direction of a Teaching Physician	• No impact on reimbursement
GE	This service has been performed by a Resident without the presence of a Teaching Physician under the Primary Care Exception	• No impact on reimbursement
GT	Via interactive audio and video telecommunications system	• Reimbursement is calculated using 50% of the Practice Expense Relative Value Unit (RVU) for the service
GM	Multiple patients on one ambulance trip	• 50% of contract allowable
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals	• 50% of contract allowable
QX	CRNA service with medical direction by a Physician	• 50% of contract allowable
QY	Medical direction of one Certified Registered Nurse Anesthetist by an Anesthesiologist	• 50% of contract allowable

Modifier	Descriptor	Reimbursement Impact/Comments
SL	State Supplied Vaccine	• No reimbursement • Append to Vaccine code • Must be appended to state-supplied vaccine codes

Developmental Testing services: append to CPT 96110.

Modifier	Descriptor
U1	Medicaid Level of Care: Completed behavioral health screening using a standardized behavioral health screening tool with no behavioral health need identified when administered by a **physician, independent nurse midwife or independent nurse practitioner.**
U2	Medicaid Level of Care: Completed behavioral health screening using a standardized behavioral health screening tool and a **behavioral health need was identified** when administered by a **physician, independent nurse midwife or independent nurse practitioner.**
U3	Medicaid Level of Care: Completed behavioral health screening using a standardized behavioral health screening tool **with no behavioral health** need identified when administered by a **nurse midwife employed by a physician.**
U4	Medicaid Level of Care: Completed behavioral health screening using a standardized behavioral health screening **tool and a behavioral health need was identified** when administered by **a nurse midwife employed by a physician**.
U5	Medicaid Level of Care: Completed behavioral health screening using a standardized behavioral health screening tool **with no behavioral health need identified** when administered **by a nurse practitioner employed by a physician**.
U6	Medicaid Level of Care: Completed behavioral health screening using a standardized behavioral health screening tool **and behavioral health need was identified** when administered **by a nurse midwife employed by a physician.**
U7	Medicaid Level of Care: Completed behavioral health screening using a standardized behavioral health screening tool **with no behavioral health need identified** when administered by a **physician assistant employed by a physician**.

Modifier	Descriptor
U8	Medicaid Level of Care: Completed behavioral health screening using a standardized behavioral health screening tool **and behavioral health need was identified** when administered by a **physician assistant employed by a physician**.
UD	Medicaid Level of Care: Completed behavioral health screening for the administration and scoring of the **Edinburgh Postnatal Depression Scale**. UD must be used together with one of the above modifiers, U1–U8.

Durable Medical Equipment

Modifier	Descriptor
KH	• Use for first month rental of capped rental items
KI	• Use for 2nd and 3rd month rental of capped rental items
KJ	• Use for months 4 to 13 for rental of capped rental items
KR	• Rental item, partial month • Bill (1) unit = (1) day rental • Billed charges must reflect daily charge
MS	• 6 months maintenance/servicing fee, reasonably necessary parts and labor which are not covered under any manufacturer or supplier warranty
NU	• New Equipment
RR	• Rental Item

Early Intervention Services

Modifier	Descriptor
AH	• Clinical Psychologist
AJ	• Clinical Social Worker
GN	• Services delivered under an outpatient speech 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

Modifier	Descriptor
HN	• Bachelor's degree level
TD	• RN
TJ	• Program group, child and/or adolescent

Serious Reportable Events

The following modifiers are required to be appended when reporting Serious Reportable Events (SRE). Please also refer to the Serious Reportable Events & Provider Preventable Conditions Provider Payment Guideline at Serious Reportable Events.

Modifier	Descriptor
PA	• Surgical or other invasive procedure on wrong body part
PB	• Surgical or other invasive procedure on wrong patient
PC	• Wrong surgery or other invasive procedure on patient

Related Documents

Ambulance
Anesthesia
DME
Early Intensive Behavioral Intervention Services
Evaluation and Management Services
General Coding and Billing
Serious Reportable Events
Vaccines and Immunizations
Authorization and Referral Guidelines

References

American Medical Association (AMA) Current Procedural Terminology (CPT)
Executive Office of Health and Human Services, 101 CMR 317.00: Rates for Medicine Services
Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements

Publication History

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July 24, 2009	*Original documentation*
May 17, 2011	*Modifiers added, genetic testing code comments, references and disclaimer updated*
August 22, 2011	*Added AI Modifier*
February 1, 2013	*Added AD Modifier*
February 1, 2014	*Template update; new format; addition of KR, GD, GH modifiers*
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May 1, 2018	*Document review; template update*
January 1, 2019	*Document restructure; Modifiers descriptor and references updated*
July 1, 2019	*QZ Modifier updated and adding modifiers U5-U8 and UD for CPT 96110*
January 1, 2023	*Document rebrand*
June 20, 2023	*Added references*
January 1, 2024	*Annual review, no policy change*
October 15, 2024	*Updated reimbursement impact on modifier grid*
January 1, 2025	*Annual review; Updated approach to multiple procedure reduction*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

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