

Modifier Reference Guide

Every common CPT modifier explained in plain English • When to use it • Common mistakes to avoid

PROFESSIONAL / SURGICAL MODIFIERS

MOD	Name	What It Means	When & Why to Use It
22	Unusual Procedural Services	The procedure took significantly more time or effort than normal.	Attach an operative report and a letter explaining what made it harder. Expect a 20–30% increase.
24	Unrelated E/M During Post-Op Period	The patient came back during the global period for a completely different problem.	Use to show the visit was NOT related to the original surgery. Document the separate diagnosis.
25	Significant, Separate E/M Same Day as Procedure	The doctor did an evaluation AND a procedure on the same visit, for separate reasons.	One of the most audited modifiers. Document clearly why both were needed on the same day.
26	Professional Component	You are billing only for the doctor's interpretation of a test (not the equipment/facility).	Used when the doctor reads/interprets a test but doesn't own the machine or facility.
27	Multiple Outpatient Hospital E/M Same Day	Patient had more than one E/M visit at the same outpatient hospital facility on the same day.	Facility use only. Identifies that a second distinct E/M occurred the same day.
32	Mandated Services	Service was required by a third party (employer, court, insurer, etc.).	Documents that this wasn't a patient-driven or physician-driven visit.
33	Preventive Service	Service is a preventive care item (ACA-covered, no cost-share to patient).	Waives patient cost-sharing. Make sure the service truly qualifies as preventive under ACA.
47	Anesthesia by Surgeon	The surgeon personally administered regional or general anesthesia.	Rare. Bill on the surgical code when the surgeon, not an anesthesiologist, provided anesthesia.
50	Bilateral Procedure	The same procedure was done on both sides of the body in the same session.	Add to the procedure code. Some payers want you to list the code twice; check payer rules.
51	Multiple Procedures Same Day	More than one procedure was done during the same surgical session.	Apply to the secondary/additional procedures. Most payers reduce payment on the secondary code.
52	Reduced Services	A procedure was started but not fully completed, or was less than what the code normally covers.	Include documentation of what was done vs. what is typical. Expect reduced reimbursement.
53	Discontinued Procedure	Procedure was stopped after starting due to a risk or complication to the patient.	Document why the procedure was stopped. Billing is for what was completed only.
54	Surgical Care Only	Surgeon performed the surgery but will NOT do the follow-up care.	Use when a different provider will handle post-op care. Split the global fee accordingly.
55	Post-Op Management Only	This provider is only managing the patient's post-operative care, not the surgery itself.	Pair with modifier 54 from the surgeon. Used to split global period care between providers.

MOD	Name	What It Means	When & Why to Use It
56	Preoperative Management Only	This provider only did the pre-op care; someone else did the surgery.	Rare. Used when pre-op management is done by a different provider than the surgeon.
57	Decision for Surgery Made at This Visit	The E/M visit is when the doctor decided that surgery was needed.	Prevents the E/M from being bundled into the global surgical package. Important for major surgery.
58	Staged or Related Procedure During Post-Op	A second procedure was done during the post-op period but was planned as a staged procedure.	Starts a new global period. Must be a planned next step in treatment, not a complication.
59	Distinct Procedural Service	Two procedures were truly separate — different session, site, incision, or injury.	Highly audited. Use only when you can document why the services are genuinely distinct.
62	Two Surgeons	Two surgeons of different specialties each performed a distinct part of the procedure.	Both surgeons bill the same code with modifier 62. Each gets ~62.5% of the fee schedule.
63	Procedure on Infant Under 4 kg	Procedure was performed on a neonate or infant weighing under 4 kg.	Documents that the procedure was significantly more complex due to patient size.
66	Surgical Team	A highly complex procedure required a team of surgeons working simultaneously.	Rarely allowed. Requires documentation of why a team was medically necessary.
76	Repeat Procedure by Same Physician	The same provider repeated the same procedure on the same day or a subsequent day.	Document why repeating was necessary. Different from a duplicate claim.
77	Repeat Procedure by Different Physician	A different provider repeated a procedure that was already done by someone else.	Prevents duplicate claim flags when repeat was done by a new provider.
78	Unplanned Return to OR for Related Complication	Patient had to go back to the OR because of a complication from the first surgery.	Still within the global period. Document the complication clearly. Does not start new global.
79	Unrelated Procedure During Post-Op Period	A completely new and unrelated procedure was done while the patient was still in a global period.	Starts a new global period. Must be truly unrelated to the original surgery.

ANESTHESIA MODIFIERS

MOD	Name	What It Means	When & Why to Use It
AA	Anesthesia Personally Performed by the Anesthesiologist	The MD anesthesiologist was personally present and performing throughout.	Full anesthesia fee. Cannot be billed with QX, QK, or QY.
AD	Medical Supervision — More Than 4 Concurrent Cases	Anesthesiologist is overseeing more than four simultaneous cases.	Reduced reimbursement. Each CRNA bills QX; the MD bills AD.
QK	Medical Direction of 2–4 Concurrent Cases	MD anesthesiologist is medically directing 2 to 4 CRNA cases at the same time.	MD bills QK; CRNA bills QX. Both get a percentage of the fee schedule.
QX	CRNA with Medical Direction	A CRNA is providing anesthesia under the direction of an MD anesthesiologist.	CRNA bills QX. Paired with QK or AD from the supervising physician.

MOD	Name	What It Means	When & Why to Use It
QZ	CRNA Without Medical Direction	The CRNA is working independently without physician direction.	CRNA bills full fee with QZ. No supervising physician bills.

EVALUATION & MANAGEMENT (E/M) MODIFIERS

MOD	Name	What It Means	When & Why to Use It
AI	Principal Physician of Record	This provider is the main attending physician responsible for the patient's overall care.	Used in inpatient settings to identify the lead physician among multiple providers.
GC	Service Performed in Part by Resident Under Teaching Physician Supervision	A resident participated in the service under the teaching physician's oversight.	Teaching physician must document their presence and participation in the note.
GE	Service Performed by Resident Without Teaching Physician Present	The resident alone performed the service — billing is limited.	Reimbursement is at a lower level. Teaching physician was not present for this service.

HCPCS / PLACE / SPECIALTY MODIFIERS

MOD	Name	What It Means	When & Why to Use It
TC	Technical Component	Billing only for the equipment/facility part of a test — not the interpretation.	Used by facilities or labs that perform the test but don't interpret it.
LT	Left Side	Procedure or service was performed on the left side of the body.	Required by many payers for laterality. Prevents claim confusion on bilateral structures.
RT	Right Side	Procedure or service was performed on the right side of the body.	Required by many payers for laterality. Always use LT and RT together for bilateral.
E1–E4	Eyelid Identifier	Identifies which eyelid was treated: E1=upper left, E2=lower left, E3=upper right, E4=lower right.	Required for ophthalmology procedures to identify the exact eyelid treated.
F1–F9, FA	Finger Identifiers	Identifies the specific finger: FA=left thumb, F1=left index ... F9=right little finger.	Required for hand and finger procedures to avoid billing ambiguity.
T1–T9, TA	Toe Identifiers	Identifies the specific toe: TA=left great toe, T1=left 2nd toe ... T9=right little toe.	Required for foot and toe procedures. Same pattern as finger modifiers.
GY	Item or Service Not Covered (Statutory Exclusion)	The service is never covered by Medicare/Medicaid by law.	Use when billing a patient directly for a non-covered service. Required for proper ABN processing.
GZ	Item Likely to Be Denied — No ABN Signed	The service may not be medically necessary and you did NOT get an ABN signed.	Flags likely denial. Patient can't be billed. Always get ABN signed when in doubt.
GA	Waiver of Liability Statement on File	An Advance Beneficiary Notice (ABN) was signed by the patient.	Protects the provider. Patient acknowledged they may be responsible if Medicare denies.

MOD	Name	What It Means	When & Why to Use It
GX	Notice of Exclusion from Medicare Benefits (NEMB) on File	Patient was told this service is excluded from Medicare benefits.	Different from GA. Used for statutory exclusions, not medical necessity issues.
QW	CLIA-Waived Test	The lab test was performed under a CLIA Certificate of Waiver.	Required for waived lab tests. Ensure your CLIA certificate is current.
95	Synchronous Telemedicine Via Real-Time Audio/Video	The service was delivered via live video telehealth.	Check payer's telehealth coverage rules. Increasingly accepted post-COVID.
GT	Via Interactive Audio and Video (Telehealth)	Service was delivered through telehealth — older HCPCS modifier.	Still used by some payers. Check if 95 or GT is preferred by the specific payer.

For internal billing team use only • Always verify payer-specific rules • Codes subject to annual updates