

## **EXHIBIT 3 MODIFIERS**

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- **AMBULANCE** - See Appendix A for a complete listing of Ambulance modifiers and their usage.

The origin and destination for each ambulance transfer must be annotated by the use of a two-digit modifier created from the following codes:

- D** Diagnostic or therapeutic site/Free standing facility (i.e., radiation therapy center)
- E** Residential/Domiciliary/Custodial Facility (i.e., non-skilled facility)
- G** Hospital Based dialysis facility (hospital or hospital related)
- H** Hospital (i.e., inpatient or outpatient)
- I** Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
- J** Non-hospital based dialysis facility
- N** Skilled Nursing Facility (SNF)
- P** Physician's Office (includes HMO non-hospital facility)
- R** Residence (patient's home) (any residence)
- S** Scene of accident or acute event (other than listed elsewhere)
- X** Intermediate stop at physician's office enroute to the hospital (Destination code only) (includes HMO non-hospital facility, clinic etc.)

The first position of the modifier represents the point of origin followed by the destination. The modifiers should be used in conjunction with the appropriate transfer code.

- **AMBULATORY SURGICAL CENTER**

**SG** Ambulatory Surgical Center (ASC) Facility Service

- **ANESTHESIA**

**AA** Anesthesia services personally furnished by anesthesiologist

**AD** Medical supervision by a physician - more than four concurrent procedures

**AG** Anesthesia for emergency surgery on a patient who is moribund (in a dying state) or who has an incapacitating systemic disease that is in constant threat of life.

**P1** A normal, healthy patient.

- P2** A patient with mild systemic disease.
- P3** A patient with severe systemic disease.
- P4** A patient with severe systemic disease that is a constant threat to life.
- P5** A moribund patient who is not expected to survive without the operation.
- P6** A declared brain-dead patient whose organs are being removed for donor purposes.
- QK** Medical direction of two, three or four concurrent anesthesia procedures.
- QS** Monitored anesthesia care service
- QX** CRNA service with medical direction by a physician
- QZ** CRNA service without medical direction by a physician
- 23** Unusual anesthesia: Occasionally because of unusual circumstances, a procedure, which usually requires either no anesthesia or local anesthesia, must be done under general anesthesia.
- 47** Anesthesia by surgeon: Regional or general anesthesia provided by the surgeon (does not include local anesthesia)
- **ASSISTANT SURGEON**
  - 32** PRO Prior Approval of Assistant at Surgery for cataract surgery
  - 80** Assistant surgeon surgical assistant services
  - 81** Minimum Assistant Surgeon
  - 82** Assistant Surgeon (when qualified resident surgeon not available)
  - AS** Physician assistant services for assistant-at-surgery (non-team member)
- **CHIROPRACTOR**
  - AT** Acute treatment. Modifier should be used when reporting service for acute treatment. (Chiropractor only)
  - ZD** Atlas or axis or C1-C7 (cervical)
  - ZE** Thoracic or dorsal T1-T12
  - ZL** Lumbar-sacral or sacro-iliac L1-L5

- ZM** More than 2 levels (Multiple)
- **DENTAL**
  - ET** Emergency treatment (dental procedures performed in emergency situations)
- **DIALYSIS:** The dialysis modifiers indicate the type of home dialysis and are used only with home dialysis supply codes.
  - EM** Emergency Reserve Supply (for ESRD supplies benefit only)
  - XU** CCPD
  - XW** Hemodialysis
  - XY** CAPD
  - XZ** IPD
  - XQ** Hemofiltration
- **EPSDT**
  - A5** TDH Regional Health Clinic by Physician
  - A6** TDH Regional Health Clinic by Physicians Assistant
  - A7** TDH Regional Health Clinic by Registered Nurse
  - A8** TDH Regional Health Clinic by Adv Nurse Practioner
  - C5** City/County Public Clinic by Physician
  - C6** City/County Public Clinic by Physicians Assistant
  - C7** City/County Public Clinic by Registered Nurse
  - C8** City/County Public Clinic by Adv Nures Practioner
  - D5** Day Care by Physician
  - D6** Day Care by Physician Assistant
  - D7** Day Care by registered Nurse
  - D8** Day Care by Advanced Nurse Practioner

- E5** FQHC by Physician
- E6** FQHC by Physicians Assistant
- E7** FQHC by Registered Nurse
- E8** FQHC by Advanced Nurse Practioner
- H5** Head Start by Physician
- H6** Head Start by Physicians Assistant
- H7** Head Start by Registered Nurse
- H8** Head Start by Advanced Nurse Practioner
- I5** Migrant Health Clinic by Physician
- I6** Migrant Health Clinic by Physicians Assistant
- I7** Migrant Health Clinic by Registered Nurse
- I8** Migrant Health Clinic by Advanced Nurse Practioner
- J5** Special State Projects by Physician
- J6** Special State Projects by Physicians Assistant
- J7** Special State Projects by Registered Nurse
- J8** Special State Projects by Advanced Nurse Practioner
- K5** Home Health Agency by Physician
- K6** Home Health Agency by Physicians Assistant
- K7** Home Health Agency by Registered Nurse
- K8** Home Health Agency by Advanced Nurse Practioner
- L5** Home by Physician
- L6** Home by Physicians Assistant
- L7** Home by Registered Nurse
- L8** Home by Advanced Nurse Practioner

- M5** Maternity Health Clinic by Physician
- M6** Maternity Health Clinic by Physicians Assistant
- M7** Maternity Health Clinic by Registered Nurse
- M8** Maternity Health Clinic by Adv Nurse Practioner
- N5** Temporary Location by Physician
- N6** Temporary Location by Physicians Assistant
- N7** Temporary Location by Registered Nurse
- N8** Temporary Location by Advanced Nurse Practioner
- O5** Office by Physician
- O6** Office by Physicians Assistant
- O7** Office by Registered Nurse
- O8** Office by Advanced Nurse Practioner
- R5** Rural Health Clinic by Physician
- R6** Rural Health Clinic by Physicians Assistant
- R7** Rural Health Clinic by Registered Nurse
- R8** Rural Health Clinic by Advanced Nurse Practioner
- S5** School by Physician
- S6** School by Physicians Assistant
- S7** School by Registered Nurse
- S8** School by Advanced Nurse Practioner
- U5** Family Planning Clinic by Physician
- U6** Family Planning Clinic by Physicians Assistant
- U7** Family Planning Clinic by Registered Nurse
- U8** Family Planning Clinic by Advanced Nurse Practioner

- V5** Mobile Van by Physician
- V6** Mobile Van by Physicians Assistant
- V7** Mobile Van by Registered Nurse
- V8** Mobile Van by Advanced Nurse Practioner
- W5** WIC Clinic by Physician
- W6** WIC Clinic by Physicians Assistant
- W7** WIC Clinic by Registered Nurse
- W8** WIC Clinic by Advanced Nurse Practioner
- **EYE**
  - AP** No eye refraction performed
  - VP** Aphakic patient
- **FOOTCARE**
  - Q7** Footcare Condition Indicator - one class A finding
  - Q8** Footcare Condition Indicator - two class B findings
  - Q9** Footcare Condition Indicator - one class B and two class C findings
  - Q1** Documentation on file for ambulatory or non-ambulatory patient that indicates mycosis / dystrophy of the toenail causing pain, secondary infection, resulting in marked limitation of ambulation and requiring the professional skills of a provider.
  - TA** Left foot, great toe
  - T1** Left foot, second digit
  - T2** Left foot, third digit
  - T3** Left foot, fourth digit
  - T4** Left foot, fifth digit

- T5** Right foot, great toe
- T6** Right foot, second digit
- T7** Right foot, third digit
- T8** Right foot, fourth digit
- T9** Right foot, fifth digit
- **HPSA**
  - QB** Physician providing services in a rural HPSA
  - QU** Physician providing services in an urban HPSA
- **OTHER SPECIAL MODIFIERS**
  - EJ** Subsequent EPO claim
  - GA** Waiver of liability statement on file.
  - QC** Single channel monitoring
  - QD** Recording and storage is solid state memory by a digital recorder
  - QT** Recording and storage on tape by an analog tape
  - Q3** Live kidney donor services associated with postoperative medical complications, directly related to the donation.
  - 22** Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure.
- **MISCELLANEOUS**
  - CC** Procedure code changed. Used when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed.
  - KM** Replacement of facial prosthesis including new impression/moulage
  - KN** Replacement of facial prosthesis using previous master model
  - LC** Left circumflex coronary artery
  - LD** Left anterior descending coronary artery

- E1** Upper left, eyelid
- E2** Lower left, eyelid
- E3** Upper right, eyelid
- E4** Lower right, eyelid
- FA** Left hand, thumb
- F1** Left hand, second digit
- F2** Left hand, third digit
- F3** Left hand, fourth digit
- F4** Left hand, fifth digit
- F5** Right hand, thumb
- F6** Right hand, second digit
- F7** Right hand, third digit
- F8** Right hand, fourth digit
- F9** Right hand, fifth digit
- QA** FDA Investigational Device Exemption (IDE)
- Q2** CABG Demonstration Project
- Q5** Service furnished by a substitute physician under a reciprocal billing arrangement.
- Q6** Service furnished by a Locum tenens physician.
- RC** Right coronary artery
- Z9** Psychiatric limitation - on outpatient psychiatric services.

- 32** Mandated Services: Services related to mandated consultation and/or related services.
- 52** Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election.
- 99** Multiple modifiers: When more than 2 modifiers are necessary to completely delineate a service.
- **PHYSICIAN**
  - AM** Physician, team member service.
  - GC** This service has been performed in part by a resident under the direction of a teaching physician.
  - GE** This service has been performed by a resident without the presence of a teaching physician under the primary care exemption.
  - LT** Left side. Used to identify procedures performed on the left side of the body.
  - RT** Right side. Used only to identify procedures performed on the right side of the body.
  - YR** Services billed as “incident to” the personal professional services of the performing physician/non-physician provider.
  - 20** Microsurgery: When the surgical service is performed using the techniques of microsurgery, including the aid of an operating microscope.
  - 21** Prolonged evaluation and management services: When the service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, place modifier 21 in the first modifier field (FA0-10.0). Note: A report may be appropriate.
  - 24** Unrelated evaluation and management service by the same physician during a postoperative period: Physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. Place a modifier 24 in the first modifier field (FA0-10.0). Note: Documentation must be available upon request.

- 25** Significant, separately identifiable evaluation and management service by the same physician on the date of a procedure: Physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. Place a modifier 25 in the first modifier field (FA0-10.0). Note: This modifier is not used to report an E&M service that resulted in a decision to perform surgery. See modifier 57.
- 50** Bilateral procedure: Bilateral procedures are procedures performed on both sides at the same operative session.
- 51** Multiple Procedures: When multiple procedures are performed at the same operative session, the major procedure may be reported as listed. The secondary, additional, or lesser procedure will be identified by modifier 51.
- 53** Discontinued procedure: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding the -53 modifier to the code for the discontinued procedure. This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and / or surgical preparation in the operating suite.
- 54** Surgical Care Only: When one physician performs a surgical procedure and another provides pre-operative and/or post-operative management.
- 55** Post-operative management only: When one physician performs the post-operative management and another physician has performed the surgical procedure.
- 56** Pre-operative management only: When one physician performs the pre-operative care and evaluation and another physician performs the surgical procedure.
- 57** Decision for surgery. An evaluation and management service that resulted in the initial decision to perform the surgery. Note: This modifier is used when the surgery is a 90-day global procedure.

- 58** Staged or related procedure or service by the same physician during the postoperative period. The physician may need to indicate that the performance of a procedure or service during the postoperative period was: (a) planned prospectively at the time of the original procedure (staged); (b) more extensive than the original procedure; or, (c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier -58 to the staged or related procedure. Note: This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier -78.
- 59** Distinct procedural service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier -59. Only if no more descriptive modifier is available, and the use of modifier -59 best explains the circumstances, should the -59 modifier be used.
- 62** Two surgeons: Under certain circumstances, the skills of two surgeons (usually with different skills) may be required in the management of a specific procedure.
- 66** Surgical team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians often of different specialties plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the "surgical team" concept.
- 76** Repeat procedure by same physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original service. This is an informational modifier only.
- 77** Repeat procedure by another physician: The physician may need to indicate that a basic procedure performed by another physician had to be repeated. This is an informational modifier only.
- 78** Return to the operating room for a related procedure during the postoperative period: Physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room includes cardiac cath suite, laser suite, and endoscopy suite. (Valid only for surgical procedures.)

**79** Unrelated procedure or service by the same physician during the postoperative period: Physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. (Valid only for surgical procedures.)

- **PHYSICIAN ASSISTANTS**

- \* **AN** Physician assistant for services for other than assistant-at-surgery (non-team member). (eg. nursing facility visits, hospital visits).

- \* **AS** Physician assistant services for assistant-at-surgery (non-team member). System will calculate 65 percent for assistant-at-surgery service.

- AU** Physician assistant for services other than assistant-at-surgery (team member).

- **OTHER PRACTITIONERS**

- AH** Clinical psychologist (CP). Used to identify clinical psychologist services when the CP is an employee.

- AJ** Clinical Social Worker (CSW). Used to identify CSW services when the CSW is an employee.

- AK** Nurse practitioner (NP), rural team member service.

- AL** Nurse practitioner, non-rural team member.

- AV** Nurse Practitioner, non-team member service (rural)

- AW** Clinical Nurse Specialist, non-team member service

- AY** Clinical Nurse Specialist, team member service

- **RADIOLOGY AND PATHOLOGY**

- LR** Laboratory round trip.

- QP** Documentation is on file showing that the laboratory test(s) was/were ordered individually or ordered as a CPT recognized panel other than automated profile codes 80002 - 80019, G0058, G0059 and G0060.

- QW** Clinical Laboratory Improvement Amendments (CLIA) waived test.

- Q4** The referring/ordering physician has a financial relationship with the laboratory but qualifies for the in-office service exception to the prohibition on referrals.

- \* **TC** Technical component only of a radiological or other procedure that has a separately identifiable technical component.

- Y1** Laboratories billing under the 30 percent exemption.
- Y7** Laboratories billing under the subsidiary related exemption.
- \* **26** Professional component only of a radiological or other procedure that has a separately identifiable technical component.

Positron Emission Tomography (PET) scan results - The first alpha character is used to indicate the result of the PET scan for the total or professional component, while the second alpha character is used to indicate the results of the prior test:

N = Negative

E = Equivocal

P = Positive, but not suggestive of extensive ischemia

S = Positive and suggestive of extensive ischemia (>20% of the left ventricle)

- \* Indicates pricing modifiers for Medicare Part B. Must be entered in first modifier field if submitted.