Washington State Department of
Labor & Industries

Appendix B: Modifiers

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Effective July 1, 2025

How to navigate this document

Use the keyboard command **CTRL+F** on Windows (**Command+F** on Mac) to search for specific topics. If you can't find what you're looking for, try different keywords or combinations of words.

The Table of Contents lists each policy. To jump to a policy, click on the page number.

Links to appendices

For definitions of terms used throughout the payment policies, see Appendix A: Definitions.

For information about place of service codes, see Appendix C: Place of Service (POS) Codes.

Updates and corrections

An annual update of the entire payment policies and fee schedules (MARFS) is published routinely to coincide with the beginning of each state fiscal year (July 1).

Throughout the year, updates and corrections may be needed to modify existing policies and fees or create new ones. Updated and corrected information supersedes the policies in MARFS. Look for possible updates and corrections to these payment policies and fee schedules on L&I's website.

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General information

Modifiers are used to report a service that has been altered by some specific circumstance, but that circumstance has not changed the service definition or code.

CPT® (HCPCS Level I) code modifiers are developed, updated, and copyrighted by the American Medical Association (AMA). HCPCS Level II modifiers are maintained and updated by Centers for Medicare and Medicaid Services (CMS).

CPT® and HCPCS modifiers aren't used with CDT® (dental) codes.

This appendix is not a comprehensive list of all modifiers. Refer to the CPT® book for a complete list of current modifiers and their definitions.

The modifiers in this appendix are used throughout the payment policy chapters and are shown in **blue text**. This information applies anywhere the modifier appears in MARFS. Modifiers are listed numerically, followed by alphabetically, and are categorized by type. L&I local code modifiers are listed alphanumerically. Description of use and payment information are included with each modifier.

Note: Many factors contribute to the resulting allowed amount for a service. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information on service and documentation requirements.

CPT® Modifiers

Use	Payment Information
–22 (Increased Procedural Services)	
Use this modifier to indicate the work to provide the service was substantially greater than typically required. Documentation in the chart note must include an explanation of the increased complexity for each service the modifier is appended to and why it was required for proper treatment. **Note**: This modifier can't be used with E/M or other leveled services.	Procedures with this modifier are reviewed and priced on an individual basis (**by report**). If allowed, payment is made at a maximum of **125%** of the fee schedule level or billed charge, whichever is less.

Use	Payment Information
–24 (Unrelated evaluation and management (E/M) service by the same physician during a postoperative period)	
Use this modifier to indicate when an E/M service is performed during a postoperative period that was unrelated to the surgical procedure. **Note**: This modifier can only be used with E/M services.	This modifier allows payment for the unrelated service. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.
–25 (Significant, separately identifiable evaluation and management (E/M) service by the same provider on the same day of the procedure or other service.)	
Use this modifier to indicate a significant, separately identifiable E/M service that went above and beyond another service provided by the same provider, for the same worker, on the same date of service. **Note**: This modifier can only be used with E/M services.	This modifier allows payment for the significant, separately identifiable E/M service. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–26 (Professional component)	
Use this modifier to indicate when only the professional component of a service is performed and reported separately. Certain procedures are a combination of a provider's professional component (**–26**) and a technical component (**–TC**). When the provider's professional component is reported separately, the service may be identified by adding this modifier. When a global service is performed, the **–26** or the **–TC** modifier can't be used. **Note**: Procedure codes that are applicable to these components are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the professional component (**–26**) rate for each specific radiology service performed or billed charge, whichever is less.

Use	Payment Information
–47 (Anesthesia by surgeon)	
Use this modifier with surgery CPT® codes to indicate when regional or general anesthesia was administered directly by the surgeon. **Note**: This modifier shouldn't be used with anesthesia CPT® codes or for services with local anesthesia.	The insurer won't pay separately for the anesthesia when this modifier is used. When the same physician performs anesthesia and surgery, the anesthesia is considered inclusive with the surgery.
–50 (Bilateral surgery)	
Use this modifier to indicate when a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using separate line items for each side of the body the procedure was performed. Apply the modifier to the second line.	The total payment is made at **150%** of the global surgery fee schedule amount for the procedure as follows: • **100%** of the global surgery fee for the procedure on the first line. • **50%** of the global surgery fee for the procedure on the second line.
–51 (Multiple surgeries)	
Use this modifier to indicate when multiple procedures were performed at the same operative session by the same individual. Providers must bill using separate line items for each procedure performed. Apply the modifier to all line items but the primary procedure. If the same procedure is performed on multiple levels, the provider must bill using separate line items for each level.	The total payment equals the sum of: • **100%** of the maximum allowable fee for the highest valued procedure according to the fee schedule, *plus* • **50%** of the maximum allowable fee for the subsequent procedure(s) with the next highest values according to the fee schedule.

Use	Payment Information
–52 (Reduced services)	
Use this modifier to indicate when a service is reduced. Under certain circumstances, a service or procedure is partially reduced or eliminated at the discretion of the provider. This modifier provides a means of reporting reduced services without disturbing the identification of the basic service. **Note**: Don't use this modifier for ASC services that require anesthesia. Instead, refer to modifiers **–73** and **–74**.	Payment is made at **50%** of the fee schedule level or billed charge, whichever is less.
–57 (Decision for surgery)	
Use this modifier to indicate that an Evaluation and Management (E/M) service resulted in the initial decision to perform the surgery. **Note**: This modifier can only be used with E/M services.	This modifier doesn't affect payment but is necessary to describe the service performed.
–58 (Staged or related procedure or service by the same physician during the postoperative period)	
Use this modifier to indicate when a surgical procedure was planned or anticipated (staged), more extensive than the original procedure, or for therapy following a surgical procedure, and is performed during the global period.	This modifier allows payment for the staged or related procedure. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–62 (Two surgeons)	
Use this modifier to indicate when 2 primary surgeons (usually with different specialties) performed distinct part(s) of the same procedure. Both surgeons must submit separate operative reports describing their specific roles.	Payment is made for each surgeon at **62.5%** of the global surgical fee or billed charge, whichever is less. No payment is made for an assistant in these cases.

Use	Payment Information
–66 (Team surgery)	
Use this modifier to indicate when a highly complex procedure is carried out by a surgical team. This requires the concomitant services of several physicians, often of different specialties, other highly skilled, specially trained personnel, and various types of complex equipment. Each surgeon must submit separate operative reports describing their specific roles.	Procedures with this modifier are reviewed and priced on an individual basis (**by report**).
–76 (Repeat procedure or service by same provider)	
Use this modifier to indicate when a procedure or service was repeated by the same provider subsequent to the original procedure or service. Documentation must include an explanation of why the procedure or service required repeating for proper treatment. **Note:** This modifier can't be appended to an E/M service.	This modifier allows payment for the repeat procedure. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–77 (Repeat procedure or service by another provider)	
Use this modifier to indicate when a procedure or service was repeated by another provider subsequent to the original procedure or service. **Note:** This modifier can't be appended to an E/M service.	This modifier allows payment for the repeat procedure. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.
–78 (Return to the operating room for a related procedure during the postoperative period)	
Use this modifier to indicate when another procedure was performed during the postoperative period of and is related to the initial procedure. The return to the operating room is for an unplanned procedure.	This modifier allows payment for the related procedure. Payment is made at a maximum of **100%** of the fee schedule level or billed charge, whichever is less.

Use	Payment Information
–79 (Unrelated procedure or service by the same physician during the postoperative period)	
Use this modifier to indicate when another procedure was performed during the postoperative period of another procedure but isn't associated with the original surgery.	This modifier allows payment for the unrelated procedure. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.
–91 (Repeat clinical diagnostic laboratory test)	
Use this modifier to indicate when repeat tests are performed on the same day, by the same provider. Specifically to obtain reportable test values with separate specimens, taken at different times, when it was necessary to obtain multiple results during the course of treatment.	This modifier allows payment for the repeat procedure. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.
–93 (via telephone or other audio-only telecommunications system)	
Use this modifier to indicate when a service was performed via audio-only. **Note: Limited to certain services.** This modifier is only applicable to certain mental health and behavioral health intervention services. See the applicable audio-only payment policy for more details.	This modifier doesn't affect payment but is necessary to describe the service.
–99 (Multiple modifiers)	
Use this modifier to indicate when more than 2 modifiers affect payment. For billing purposes only, include only this modifier with the service(s) performed on the billing form, along with any modifiers not affecting payment. In the remarks section of the billing form, include the individual descriptive modifiers that affect payment.	This modifier doesn't affect payment but is necessary to accommodate all modifiers billed. Payment is based on the policy associated with each individual modifier that describes the actual services performed.

Surgical package modifiers

When providing less than the global surgical package, providers should use modifiers **–54**, **–55**, or **–56**. These modifiers are designed to ensure that the sum of all allowances for all providers doesn't exceed the total allowance for the global surgery period.

These modifiers allow direct payment to the provider for each portion of the global surgery service.

Use	Payment Information
–54 (Surgical care only)	
Use this modifier to indicate when the physician performs a surgical procedure but another physician provides preoperative and/or postoperative management.	Payment is made at the percentage of the fee schedule amount noted in the modifier **–54** column of the Professional Services Fee Schedule. If the percentage column is **0%**, payment is made at **100%** of fee schedule level or billed charge, whichever is less.
–55 (Postoperative care only)	
Use this modifier to indicate when the physician performs the postoperative management but another physician has performed the surgical procedure.	Payment is made at the percentage of the fee schedule amount noted in the modifier **–55** column of the Professional Services Fee Schedule. If the percentage column is **0%**, payment is made at **100%** of fee schedule level or billed charge, whichever is less.
–56 (Preoperative care only)	
Use this modifier to indicate when the physician performs the preoperative care and evaluation but another physician performs the surgical procedure.	Payment is made at the percentage of the fee schedule amount noted in the modifier **–56** column of the Professional Services Fee Schedule. If the percentage column is **0%**, payment is made at **100%** of fee schedule level or billed charge, whichever is less.

Assistant surgeon modifiers

Physicians who assist the primary physician in surgery should use modifiers **–80**, **–81**, or **–82**, depending on the medical necessity. The insurer doesn't recognize modifier **–AS**.

Refer to the assistant surgeon indicator in the Professional Services Fee Schedule to determine if assistant surgeon fees are payable. If the fee schedule indicator lists a procedure as not usually payable, justification for the necessity of an assistant surgeon must be documented in the surgeon's report to receive payment.

Use	Payment Information
–80 (Assistant surgeon)	
Use this modifier to indicate when the physician assisted on a surgery as the assistant surgeon.	Payment is made at **20%** of the global surgery fee for the procedure or billed amount, whichever is less.
–81 (Minimum assistant surgeon)	
Use this modifier to indicate when the physician only assisted on part of a surgery as the assistant surgeon.	Payment is made at **20%** of the global surgery fee for the procedure or billed amount, whichever is less.
–82 (Assistant surgeon (when qualified resident surgeon not available))	
Use this modifier to indicate when the physician assisted on a surgery when a qualified resident surgeon was not available to assist the primary surgeon.	Payment is made at **20%** of the global surgery fee for the procedure or billed amount, whichever is less.

Ambulatory Surgery Center (ASC) hospital outpatient only modifiers

The following modifiers are only for use in an ASC and hospital outpatient setting. Refer to the CPT® book for a complete list of modifiers for use by ASC and other hospital outpatient facilities.

Use	Payment Information
–73 (Discontinued procedures prior to the administration of anesthesia)	
Use this modifier to indicate when a physician cancels a surgical procedure due to the onset of medical complications or extenuating circumstances subsequent to the worker's preparation (including sedation), but prior to the administration of anesthesia (local, regional block(s) or general). **Note:** For use in ASC and outpatient hospital only; not physician reporting.	Payment is made at **50%** of the fee schedule level or billed charge, whichever is less.
–74 (Discontinued procedures after administration of anesthesia)	
Use this modifier to indicate when a physician terminates a surgical procedure due to the onset of medical complications or extenuating circumstances after the administration of anesthesia (local, regional block(s) or general) or after the procedure was started. **Note:** For use in ASC and outpatient hospital only; not physician reporting.	Payment is made at **60%** of the fee schedule level or billed charge, whichever is less.

HCPCS modifiers

Use	Payment Information
–FT (Unrelated critical care evaluation and management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit.)	
Use this modifier to indicate when a critical care E/M visit is furnished within the postoperative period but is unrelated to the surgery.	This modifier allows payment for the unrelated service. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.
–FR (Direct supervision via telehealth)	
Use this modifier to indicate when direct supervision of a student is provided via telehealth. **Note:** Direct supervision for physical therapy (PT) or occupational therapy (OT) students must be performed in person. Modifier **–FR** is not allowed.	This service is only payable when the service provided to the worker is allowed via **telehealth**. Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.
–GT (Service performed via telehealth)	
Use this modifier to indicate when a service was performed via telehealth. This modifier can't be used if the CPT® code includes audio-visual (telehealth) as part of the service description. **Note:** Modifier –95 (telehealth service) isn't recognized by the insurer.	This modifier doesn't affect payment but is necessary to describe the service. Payment is based on the Place of Service (POS) billed with the telehealth service and this modifier. See the telehealth payment policy in this chapter for more information.
–GM (Multiple workers, one ambulance trip)	
Use this modifier to indicate when multiple workers are being transported in the same ambulance trip.	This modifier doesn't affect payment but is necessary to describe the service.

Use	Payment Information
–LT (Left side)	
Use this modifier to indicate when a procedure or service was performed on the left side of the body. Specifically for procedures or services that can be performed on contralateral sites, paired organs, or extremities.	This modifier doesn't affect payment but is necessary to describe the service. Its use will help reduce duplicate bills and minimize payment delays.
–NU (New purchased DME)	
Use this modifier to indicate when the DME dispensed is being purchased and doesn't need to be returned to the supplier. **Note**: DME codes that are applicable to purchasing are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the modifier **–NU** rate for each specific DME provided or billed charge, whichever is less.
–RR (Rented DME)	
Use this modifier to indicate when the DME dispensed will be rented and returned to the supplier. **Note**: DME codes that are applicable to rental are listed in the L&I Professional Services Fee Schedules	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the modifier **–RR** rate for each specific DME provided or billed charge, whichever is less.
–RT (Right side)	
Use this modifier to indicate when a procedure or service was performed on the right side of the body. Specifically for procedures or services that can be performed on contralateral sites, paired organs, or extremities.	This modifier doesn't affect payment but is necessary to describe the service. Its use will help reduce duplicate bills and minimize payment delays.
–SU (Procedure performed in physician's office)	
This modifier isn't recognized by the insurer.	Facility fees are not payable for procedures performed in a physician's office. Services with this modifier will be **denied**.

Use	Payment Information
–TC (Technical component)	
Use this modifier to indicate when only the technical component of a service is performed and reported separately. Certain procedures are a combination of a provider's professional component (**–26**) and a technical component (**–TC**). When the provider's technical component is reported separately, the service may be identified by adding this modifier. When a global service is performed, the **–26** or the **–TC** modifier can't be used. **Note**: Procedure codes that are applicable to these components are listed in the L&I Professional Services Fee Schedules.	These services are represented by their own line on the professional services fee schedule. Payment will be made at **100%** of the technical component (**–TC**) rate for each specific radiology service performed or billed charge, whichever is less.
–UN (2 workers served – portable radiology)	
Use this modifier to indicate when 2 workers are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.
–UP (3 workers served – portable radiology)	
Use this modifier to indicate when 3 workers are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.
–UQ (4 workers served – portable radiology)	
Use this modifier to indicate when 4 workers are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.
–UR (5 workers served – portable radiology)	
Use this modifier to indicate when 5 workers are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.
–US (6 or more workers served – portable radiology)	
Use this modifier to indicate when 6 or more workers are served using portable radiology equipment.	This modifier doesn't affect payment but is necessary to describe the service.

Anesthesia modifiers

When billing for anesthesia services paid with base and time units, anesthesiologists and CRNAs should use the following modifiers.

Note: Except for modifier **–99**, the following modifiers aren't valid for anesthesia services paid based on maximum provider fee schedule.

Use	Payment Information
–AA (Anesthesia services performed personally by anesthesiologist)	
Use this modifier to indicate when anesthesia services were performed personally by the anesthesiologist.	This modifier doesn't affect payment but is necessary to describe the service.
–QK (Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals)	
Use this modifier to indicate when a physician has provided medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals. **Note:** This modifier is for physician use only.	See Team care payment policy for payment information.
–QX (CRNA service: with medical direction by a physician)	
Use this modifier to indicate when a Certified Registered Nurse Anesthetist (CRNA) provides anesthesia services with medical direction by a physician.	See Team care payment policy for payment information.
–QY (Medical direction of 1 certified registered nurse anesthetist (CRNA) by an anesthesiologist)	
Use this modifier to indicate when a physician has provided medical direction of 1 Certified Registered Nurse Anesthetist (CRNA) for a single anesthesia procedure. **Note:** This modifier is for physician use only.	See Team care payment policy for payment information.

Use	Payment Information
–QZ (CRNA service: without medical direction by a physician)	
Use this modifier to indicate when a Certified Registered Nurse Anesthetist (CRNA) has provided anesthesia services without medical direction by a physician.	Payment is made at **100%** of the fee schedule level or billed amount, whichever is less.

L&I local code modifiers

Use	Payment Information
–1S (Surgical dressings for home use)	
Use this modifier to indicate when surgical dressing supplies are dispensed for home use. Bill with the appropriate HCPCS code for each dressing item.	Services with this modifier may be bundled, based on who is providing the dressings. If not bundled, payment is made at **100%** of the fee schedule level or billed charge, whichever is less.
–7N (Services in conjunction with an IME)	
Use this modifier to indicate when services are requested for an IME.	This modifier doesn't affect payment but is necessary to describe the service performed.
–8R (COHE modifier for case management codes and consultations)	
Use this modifier to indicate when the billing provider is part of a Centers of Occupational Health & Education (COHE) program.	Payment is made at **110%** of the fee schedule level or billed charge, whichever is less.
–8S (Health/Surgical health services coordination by a Health Services Coordinator)	
Use this modifier to indicate when a second billable HSC case note on the same day, for the same claimant, under the same claim. Bill each case note on separate lines and apply this modifier to the second line.	Payment for the second case note is made at **50%** of the fee schedule level or billed charge, whichever is less.

Need more help?

Contact Provider Hotline with billing and authorization questions by emailing PHL@Lni.wa.gov or calling **1-800-848-0811** between 8 am and 12 pm PT Monday through Friday.

