BlueCross BlueShield of North Carolina

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Corporate Reimbursement Policy

Modifier Guidelines

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Description

A modifier enables a provider to report that a service or procedure has been altered by some specific circumstance, when that circumstance is not defined by a different code. The use of modifiers eliminates the need for separate procedure listings that may describe the modifying circumstances. Modifiers may be used to indicate that:

- A service or procedure has a professional or technical component.
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure has been increased or reduced.
- Only part of a service was performed.
- An add-on or additional service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.
- A service or procedure was performed on a specific site.

Certain modifiers are used for informational purposes only, and do not affect payment amounts.

Related Corporate Reimbursement Policies:

Bundling Guidelines
Co-Surgeon, Assistant Surgeon, Team Surgeon, and Assistant-at-Surgery
Maximum Units of Service
Multiple Surgical Procedure Guidelines for Professional Providers
Radiology Services Reimbursement Policy
Telehealth

Policy

CPT modifiers that may affect claims payment are: 24, 25, 26, 47, 50, 51, 52, 54, 55, 56, 57, 59, 62, 66, 79, 80, 81, and 82.

HCPCS modifiers that may affect claims payment are: AJ, AS, AX, TC, E1-E4, FA-F9, GQ, GT, TA-T9, RT, LT, LC, LD, LM, MS, P3, P4, P5, PA, PB, PC, RA, RB, RC, RI, QW, SH, and SJ.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

Modifier Guidelines

Modifier Guidelines

- Modifier 22 will not affect claims processing adjudication. In general, BCBSNC does not allow a severity adjustment to fee allowances. Payment for new technologies is based on the outcome of the treatment rather than the "technology" involved in the procedure.

- Modifier 24 is used to report an evaluation and management service performed during a postoperative period by the same physician or same group practice for reasons unrelated to the original procedure.

- Modifier 25 is used to indicate that the evaluation and management service was significant and separately identifiable from a minor procedure performed on the same day.

  The modifier 25 will not be recognized with a minimal office visit for an established patient (99211) performed on the same date as a preventive medicine visit (99391 - 99397).

  Evaluation and management services performed the same day as a 0 or 10-day global medical or surgical service will be denied as included in the global surgical package, unless the service was significant and separately identifiable from the minor procedure and is indicated with modifier 25.

- Modifier 26 designates the professional component of a procedure. When the physician's component is separately reportable, the service may be identified by appending modifier -26 to the procedure code.

- Modifier 47 is used to report anesthesia by the attending or assistant surgeon. No additional benefits are allowed above the total allowed for the surgical procedure if the anesthesia services are not administered by, or under the supervision of, a doctor other than the attending surgeon or assistant surgeon.

- Modifier 50 designates a bilateral procedure performed at the same session. Use of the 50 modifier will not result in additional reimbursement when used with procedures which cannot be performed bilaterally or for which the base CPT code signifies a bilateral procedure.

- Modifier 51 designates multiple procedures that are performed at the same session by the same provider, other than evaluation and management services, physical medicine and rehabilitation services, or provision of supplies.

  Modifier 51 will not be accepted with evaluation and management services. This modifier is not to be appended to designated "add-on" codes.

- Modifier 52 indicates that a service or procedure has been partially reduced or eliminated at the physician's discretion.

- Modifiers 54, 55 and 56 designate Split Surgical Care. (See Policy Guidelines for additional information on Modifier 54)

- Modifier 57 is an evaluation and management service that results in the initial decision to perform surgery. It is intended to report that the decision to perform major surgery occurred on the day of or day prior to, a major (90-day global) surgical procedure.

Modifier Guidelines

Modifier 57 should not be appended to an evaluation and management service associated with a major surgery that has been planned in advance. Some categories of planned surgery would be inconsistent with a decision for surgery occurring the day of, or day prior to, the procedure, except when performed in the setting of an office or inpatient consultation, or emergency department. Categories of these planned surgeries include, but are not limited to: spine surgery (excluding fractures and dislocations), arthroplasty (total, partial, revision), congenital/deformity procedures, chronic/sub-acute conditions, and transplant procedures. Evaluation and management services with modifier 57 for these categories of planned surgery will be denied when billed outside the consultative and emergency settings noted above.

Evaluation and management services performed the same day as a 90-day global medical or surgical service will be denied as included in the global surgical package, unless the service consisted of a decision for surgery and is indicated with modifier 57.

- Modifier 59 designates that a procedure is distinct or independent from another non-evaluation and management service performed on the same day.

  Modifier 59 (or XE, XS, XP, XU) will not allow additional payment when appended to CPT4 codes 63005, 63012, 63017, 63030, 63035, 63042, 63044, 63047 and 63048 when performed in conjunction with 22630, 22632, 22633 and/or 22634. Based on the most common clinical scenario it is expected that when a lumbar laminectomy, facetectomy, and/or foraminotomy is billed with a lumbar arthrodesis, posterior interbody technique, the procedures are being performed on the same level. In the unusual clinical circumstance when the procedures are performed at different vertebral levels, clinical information will be required to be submitted on appeal.

  Modifier 59 (or XE, XS, XP, XU) will not allow additional payment when a diagnostic endoscopic base code is submitted with a surgical endoscopic code from the same endoscopic family. The endoscopic family is defined by the Medicare Physician Fee Schedule.

  The Centers for Medicare & Medicaid Services (CMS) has established four HCPCS modifiers to define subsets of the 59 modifier. These modifiers function in the same manner as modifier 59.
    - XE Separate Encounter. A service that is distinct because it occurred during a separate encounter.
    - XS Separate Structure. A service that is distinct because it was performed on a separate organ/structure.
    - XP Separate Practitioner. A service that is distinct because it was performed by a different practitioner.
    - XU Unusual Non-Overlapping Service. The use of a service that is distinct because it does not overlap usual components of the main service.

- Modifiers 62 and 66 designate services performed by two surgeons or a surgical team, and will be reviewed on an individual consideration basis.

- Modifiers 80, 81, and 82 are used to report assistant surgeon services. Blue Cross and Blue Shield of North Carolina uses ClaimCheck® as its primary source for determining those procedures available for assistant surgeon benefits. The assistant surgeon classifications assume that the assistant surgeon is board-certified or otherwise highly qualified as a skilled surgeon. Automatic edits are performed on assistant surgeon claims to determine if any

procedures have been inappropriately billed by a surgical assistant. If guidelines are not met, the claim will suspend.

- Modifier 95 is used to designate when a service is a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional.

- Modifier AS designates that services were provided by a physician assistant, nurse practitioner or nurse midwife for an assistant at surgery. Blue Cross and Blue Shield of North Carolina uses ClaimCheck® as its primary source for determining those procedures available for assistant surgeon billing by physician assistants, nurse practitioner or nurse midwife. Automatic edits are performed to determine if any procedures have been inappropriately billed by the physician assistant, nurse practitioner or nurse midwife.

- Modifier AX – item furnished in conjunction with dialysis services. J0604 and J0606 are drugs used for bone and mineral metabolism for the treatment of End Stage Renal Disease. They are eligible for Transitional Drug Add-On Payment Adjustment when billed with AX modifier.

- HCPCS Level II anatomic specific modifiers E1-E4 (eyelids), FA-F9 (fingers), TA-T9 (toes), RC, LC, LD, RI, LM (coronary arteries), and RT / LT (right / left) designate the area or part of the body on which the procedure is performed. Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims. (See also reimbursement policy titled “Maximum Units of Service”). Modifier 50 is used when bilateral procedures are performed on both sides at the same operative session. (See also reimbursement policy titled “Multiple Surgical Procedure Guidelines for Professional Providers”).

- Modifier GQ designates services performed via asynchronous telecommunications system and will not be allowed.

- Modifier GT designates services performed via interactive audio and video telecommunication systems and will be allowed with codes specified in the Corporate Reimbursement Policy titled, “Telehealth.”

- Modifier MS - six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty

- For Modifiers PA (surgical or other invasive procedure on wrong body part), PB (surgical or other invasive procedure on wrong patient), and PC (wrong surgery or other invasive procedure on patient), refer to Corporate Reimbursement Policy titled “Nonpayment for Serious Adverse Events”

- Modifier RA – Replacement of a DME item

- Modifier SZ – Effective 1/1/2017 in order to support Control/Home Plans’ compliance with the Federal requirement to separate visit limits for habilitative and rehabilitative services, Par/Host Plans may need to require that their providers are using the HCPCS modifier “SZ” when billing for habilitative services. (See policy titled “Rehabilitative Therapies”)

- Modifier RB – Replacement of a part of DME furnished as part of a repair

- Modifier TC designates the technical component of a service. When the technical component is separately reportable, the service may be identified by appending modifier TC to the procedure code.

Policy Guidelines

Claims with inappropriate modifier to procedure code combinations will be denied. Claims must be resubmitted with correct modifier for payment.

When a fracture care code is billed in the office setting and the same code has been billed in the past 2 weeks, it is assumed that the second billing of this code is duplicative, and it will be denied. When a fracture care code is billed in the office setting that is different from another fracture care code that was billed in the previous 2 weeks, it is assumed that the second code was inappropriately coded and that it also represents post-operative care for the earlier service. In this situation, the second code will be denied. An exception exists for procedures billed with an appropriate modifier which designates that the services are unrelated. The modifiers are listed below:

-55 (Post-operative management only)
-76 (Repeat procedure by same physician)
-77 (Repeat procedure by another physician)
-78 (Return to operating room for a related procedure during the post-operative period)
-79 (Unrelated procedure or service by same physician during the post-operative period)

Modifier 54 (surgical care only) is not appropriate to use with fracture care codes for closed treatment without manipulation in the emergency department.

See also Corporate Reimbursement Policy titled "Bundling Guidelines" for discussion of the Global Allowance.

Physicians should report appropriate anesthesia modifiers with general anesthesia services to denote whether the service was personally performed, medically directed, medically supervised or represented monitored anesthesia care. Also, services rendered by CRNAs must report the appropriate anesthesia modifier to indicate whether the service was performed with or without medical direction by a physician. Appropriate modifiers for anesthesia services are: AA, AD, G8, G9, QK, QS, QX, QY, and QZ General anesthesia services (CPT 00100-01969)***** will be denied if billed without an appropriate modifier. (See also Corporate Medical Policy titled, "Anesthesia Services")

*****01960 and 01967 are considered non-timed procedures and therefore do not require a modifier.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: *Reimbursement for a procedure code/modifier combination will be considered only then the modifier has been used appropriately in accordance with correct coding principles.*

Modifier Guidelines

Scientific Background and Reference Sources

Medical Policy Advisory Group - 10/2003

Medical Policy Advisory Group - 03/10/2005

Senior Medical Director – 3/2011

Medical Director review – 1/2012

Medical Director review – 12/2013

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf

Medical Director review – 12/2014

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R1999OTN.pdf

Policy Implementation/Update Information

1/00	Implementation
1/00	Revised to correct billing guideline for modifier -50.
3/00	Removed Blue Edge reference.
8/00	Clarification that -59 modifier will affect claims processing for Blue Care, Blue Choice, Blue Options, and Classic Blue in the 'When it is covered' and 'When it is not covered' sections.
01/02	Updated information pertaining to the place of service for a -25 modifier. Section added to indicate when a -25 modifier is not covered. Added information pertaining to the -57 modifier in both the covered and non-covered sections.
05/03	Added modifier - MS and -RP in the 'When it is covered' section.
10/03	Medical Policy Advisory Group review - 10/2003.
02/04	This policy applies to Blue Care, Blue Choice, Blue Options, and Classic Blue products only. Clarified this point in the policy. Statement removed from modifier -59 explanation.
4/07/05	Medical Policy Advisory Group reviewed policy on 03/10/2005. Medpoint and PCP removed from this policy. Corrected typos.
3/16/06	Renamed sections "When it is covered" and "When it is not covered" to read "When a modifier may be covered" and "When a modified may not be covered." Added the policy number to Key Words section. Added the following statement "Blue Cross and Blue Shield of North Carolina uses the American College of Surgeons as its primary source for determining those procedures available for assistant surgeon benefits to

Modifier -80, -81, -82 and AS. Modifier -21 removed from policy. .Statement that applied to PPO/CMM was removed from modifier -59.

5/8/06 Added statement to the section "When a modifier may not be covered" to read: Modifier -22 will not affect claims processing adjudication. In general, BCBSNC does not allow a severity adjustment to fee allowances. Payment for new technologies is based on the outcome of the treatment rather than the "technology" involved in the procedure. Added policy number to Key Words section. Medical Policy Advisory Group review 3/24/06 including revisions noted above. No additional changes required to policy criteria.

10/16/06 In the section "When a Modifier may be covered" revised procedure(s) to service(s) pertaining to Modifier -25. Statement added "The - 25 modifier will not be recognized with a minimal office visit for an established patient (99211) performed on the same date as a preventative medicine visit (99391 - 99397)." Removed the statement "Modifier - 25 is not recognized for an separate E&M service performed on the same date as a preventive medicine visit." in the section "When a Modifier may not be covered."

9/10/07 Modifier GT - Via interactive audio and video telecommunication systems will be allowed with code 99201 - 99205, 99212 - 99215(Office or Other Outpatient Services) and 99241 - 99245 (Office or Other Outpatient Consultations) added to "When a Modifier may be covered". Modifier GQ - Via asynchronous telecommunications system will not be allowed specifically with code 99201 - 99215(Office or Other Outpatient Services) and 99241 - 99245(Office or Other Outpatient Consultations) and Modifier GT - will not be recognized with a minimal office visit for an established patient (99211) added to "When a modifier may not be covered". Modifier GT - will not be recognized with a minimal office visit for an established patient (99211) added to "When a modifier may not be covered." Added to Policy Guidelines: BCBSNC does not reimburse for evaluation and management and consultation services provided via telephone, Internet, or other communication network or devices that do not involve direct, in-person patient contact. Revised wording related to modifier 57 from "Modifier - 57 designates the decision to do surgery. It is accepted only with inpatient and observation E&M codes when the decision is made to do a major surgical procedure. A major surgical procedure is defined as one with a 90 day global period. The global period starts the day prior to surgery. The modifier is appropriate to signify that the decision was made to do a major surgery procedure within the global period." to "Modifier 57 - is an evaluation and management service that results in the initial decision to perform surgery." from "When a modifier may be covered." Statement "Modifier -57 will not be recognized with any E&M code other than inpatient or observation" removed from "When a modifier may not be covered". Medical Policy reviewed 08/17/07 by Senior Medical Director of Provider Partnerships, Medical and Reimbursement Policy.

12/03/07 Reference added to clarify that "Blue Advantage" applies to this policy. Statement, "Modifier -25 will not be recognized with inpatient E&M services." removed from "When a Modifier may not be covered".

07/20/09 Added modifier -54, -55, and -56 to "When a Modifier may be covered." Removed references related to American College of Surgeons. Added nurse practitioner and nurse midwives to modifier "AS". New modifiers PA, PB and PC are effective 7/1/2009, which describe serious adverse events. Removed references to Blue Advantage, Blue Care, Blue Choice, Blue Options, and Classic Blue Products Policy

reviewed by VP/ Senior Medical Director of Provider Partnerships, Medical and Reimbursement Policy.

6/22/10 Policy Number(s) removed (amw)

09/14/10 Removed "BCBSNC does not reimburse for evaluation and management and consultation services provided via telephone, Internet, or other communication network or devices that do not involve direct, in-person patient contact." Added modifier -52, -RA and –RB and deleted modifier RP. Policy reviewed by VP/ Senior Medical Director, Healthcare Quality.

3/15/11 Added Modifier -59 will not allow additional payment when appended to CPT4 codes 63005, 63012, 63017, 63030, 63035, 63042, 63044, 63047 and 63048 and when performed in conjunction with 22630 and 22632. Lumbar laminectomy, facetectomy and foraminotomy procedures are typically considered incidental to the lumbar arthrodesis, posterior interbody technique; and therefore are not eligible for separate reimbursement. Changes to policy reviewed by Senior Medical Director 3/10/2011. Notification given 3/15/2011. Policy effective 6/19/2011. Added "same group practice" to modifier 24.(dpe)

06/07/11 Further clarification of Modifier -59; added the following statements: "Based on the most common clinical scenario, it is expected that when a lumbar laminectomy, facetectomy, and/or foraminotomy is billed with a posterior lumbar interbody fusion, the procedures are being performed on the same level. In the unusual clinical circumstance when the procedures are performed at different vertebral levels, clinical information will be required to be submitted on appeal." (dpe)

3/6/12 Revised the definitions of the modifiers. The sections formerly titled "when a modifier may be covered" and "when modifiers may not be covered" were combined into one section titled "when a modifier may affect claims payment." Information added to the Policy Guidelines section regarding fracture care codes and anesthesia modifiers. (adn)

12/10/13 In the "Policy" section, deleted modifier 22 from the list of modifiers that may affect claims payment. In the "Modifier Guidelines" section, bulleted section on Modifier 59: added codes 22633 and 22634 so that the statement reads: "Modifier 59 will not allow additional payment when appended to CPT4 codes 63005, 63012, 63017, 63030, 63035, 63042, 63044, 63047 and 63048 when performed in conjunction with 22630, 22632, 22633 and/or 22634." Statement regarding anatomic-specific modifiers was reworded and modifiers LM and RI added to the list of coronary artery anatomic modifiers. In the "Policy Guidelines" section: deleted the statement "BCBSNC claims system processes only one modifier per CPT code." Notification given 12/10/13 for effective date 2/11/14. (adn)

5/13/14 Policy category changed from "Corporate Medical Policy" to "Corporate Reimbursement Policy". No changes to policy content. (adn)

12/30/14 The Centers for Medicare & Medicaid Services (CMS) has established four HCPCS modifiers to define subsets of the -59 modifier. Modifiers XE, XS, XP, and XU added to the -59 modifier section. BCBSNC will continue to recognize

the -59 modifier. The CMS modifiers (XE, XS, XP, XU) are considered informational only. (adn)

7//28/15 Added "AJ, P3, P4, P5, QW, SH, SJ" to list of HCPCS modifiers that may affect claims payment. Revised Modifier GQ to read: services performed via asynchronous telecommunications system will not be allowed. Revised Modifier GT to read: services performed via interactive audio and video telecommunication systems will be allowed with codes specified in corporate reimbursement policy titled, "Telehealth." (adn)

9/1/15 The following statement was deleted from the paragraph regarding Modifier 59: "BCBSNC will continue to recognize the 59 modifier. The CMS modifiers (XE, XS, XP, XU) are considered informational only." (adn)

12/30/16 The following guideline added: Effective 1/1/2017 in order to support Control/Home Plans' compliance with the Federal requirement to separate visit limits for habilitative and rehabilitative services, Par/Host Plans may need to require that their providers are using the HCPCS modifier "SZ" when billing for habilitative services. (See policy titled "Rehabilitative Therapies"). Information added regarding modifier 95. (an)

3/31/17 Modifier 59 (or XE, XS, XP, XU) will not allow additional payment when a diagnostic endoscopic base code is submitted with a surgical endoscopic code from the same endoscopic family. The endoscopic family is defined by the Medicare Physician Fee Schedule. **Notification given 3/31/2017 for policy effective date of 5/26/2017.** (an)

7/28/17 Modifier 54 (surgical care only) is not appropriate to use with fracture care codes for closed treatment without manipulation in the emergency department. **Notification given 7/28/2017 for policy effective date of 9/29/2017.** (an)

11/28/17 HCPCS Level II anatomic specific modifiers E1-E4 (eyelids), FA-F9 (fingers), TA-T9 (toes), RC, LC, LD, RI, LM (coronary arteries), and RT / LT (right / left) designate the area or part of the body on which the procedure is performed. Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims. (See also reimbursement policy titled "Maximum Units of Service"). Modifier 50 is used when bilateral procedures are performed on both sides at the same operative session. (See also reimbursement policy titled "Multiple Surgical Procedure Guidelines for Professional Providers"). **Notification given 11/28/17 for effective date of 1/27/18.** (an)

2/9/18 Modifier AX – item furnished in conjunction with dialysis services. J0605 and J0606 are drugs used for bone and mineral metabolism for the treatment of End Stage Renal Disease. They are eligible for Transitional Drug Add-On Payment Adjustment when billed with AX modifier. **Notification given 2/9/2018 for policy effective date 4/13/2018.** (an)

4/27/18 Correction for codes related to Modifier AX. Correct codes are **J0604** and J0606. (an)

Modifier Guidelines

12/31/18	Routine annual review. No change to current policy. (an)
4/30/19	Corrected typo. Modifier “SP” changed to “XP” throughout. (an)
1/14/20	Routine policy review. Senior Medical Director approved 12/2019. No changes to policy statement. (an)
11/24/20	Policy guidelines updated with “*01960 and 01967 are considered non-timed procedures and therefore do not require a modifier.” No change to policy statement. (eel)