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 reimbursement.

Policy

Blue Cross Blue Shield North Carolina (Blue Cross NC) utilizes modifiers in determining reimbursement and eligibility. Services billed with inappropriate modifiers or that lack the appropriate modifier according to this policy will not be eligible for reimbursement.

Reimbursement Guidelines

Modifiers Defined by CPT® Appendix A

- Modifier 22 will not affect claims processing adjudication. In general, Blue Cross NC 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. See “Global Surgery” reimbursement policy.

- Modifier 25 – See “Evaluation and Management Services” reimbursement policy.

- 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 is not appropriate to append to 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, per CMS, modifier 52 is subject to a pricing reduction.

- Modifiers 54, 55 and 56 designate split surgical care. (see related “Split Surgical Package” reimbursement policy)

- 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. See “Global Surgery” reimbursement policy regarding appropriate use of Modifier 57.

  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.

  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. Since the HCPCS modifiers are more detailed descriptions of modifier 59, it would be incorrect to include both on the same claim line according to CMS. Therefore, any code appended with 59 in addition to XE, XS, XO, or XU will not be eligible for reimbursement.

  - 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. See "Co-Surgeon, Assistant Surgeon, Team Surgeon and Assistant-at-Surgery Guidelines" reimbursement policy.

- Repeat Procedures, Unplanned Return to the Operating Room, and Unrelated Procedures. See also "Global Surgery" reimbursement policy.

  - A procedure code billed with modifier 76 will not be eligible for reimbursement unless Blue Cross NC has received a claim indicating that the same provider using the same provider ID also performed that same service on the same date or within the post operative period.

  - Similarly, a procedure code billed with modifier 77 will not be eligible for reimbursement unless Blue Cross NC has also received a claim indicating that a different provider using a separate provider ID has also performed that same service on the same date as the original service or within the post operative period.

  - In order for a procedure code billed with modifier 78 or 79 to be eligible for reimbursement, Blue Cross NC must have evidence that a procedure was billed on the same date of service or within the post operative period as defined by the 0, 10, or 90 day post operative period definition.

- Modifiers 80, 81, and 82 are used to report assistant surgeon services. Blue Cross NC uses CMS 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 90 represents a reference (outside) laboratory and will only be eligible for reimbursement if billed by a provider with a specialty designation of Laboratory or Pathology.

- Modifier 92 is used for alternative laboratory platform testing. Only HIV testing will be eligible for reimbursement when billed. All other codes containing this modifier will not be eligible for reimbursement.

- 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 Use in Fracture Care

  When a fracture or dislocation care code is billed in the office setting and the same code has been billed by any provider in the past 10 days, 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.

Level II HCPCS/National Modifiers

- Modifier AS designates that services were provided by a physician assistant, nurse practitioner or nurse midwife for an assistant at surgery. Blue Cross NC uses CMS 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. Drugs used for bone and mineral metabolism for the treatment of End Stage Renal Disease are eligible for Transitional Drug Add-On Payment Adjustment when billed with AX modifier.

- Enteral nutrients are not eligible for reimbursement when billed with the BO modifier.

- 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. Orthotics, prosthetics and wheelchair accessories require anatomic modifiers. (See also reimbursement policy titled “Maximum Units of Service”).

- Erythropoiesis stimulating agent (ESA) treatment requires modifier usage; to include EA, EB, or EC.
    - Modifier EA - Erythropoietic stimulating agent (ESA) administered to treat anemia due to anticancer chemotherapy.
    - Modifier EB - Erythropoietic stimulating agent (ESA) administered to treat anemia due to anticancer radiotherapy.
    - Modifier EC - Erythropoietic stimulating agent (ESA) administered to treat anemia not due to anticancer radiotherapy or anticancer chemotherapy.

- Therapy Service modifiers include GN, GO, and GP. These modifiers are required to be appended to therapy services, such as speech-language, occupational, and physical therapies. Therefore, any speech-language therapy service will require the GN modifier. Any occupational therapy service will require the GO modifier. Finally, any physical therapy service will require the GP modifier. These include evaluation and re-evaluation codes and “sometimes” code when billed by a speech language pathologist, occupational or physical therapist. There should only be one of the aforementioned modifiers per code per claim line. Any non-therapy service that is appended with a therapy modifier will not be eligible for reimbursement. Additionally, should a therapy service include the use of an outpatient occupational or physical therapy assistant, the appropriate modifier (CO or CQ) will also need to be added to that claim line.

  Physical medicine and rehabilitation services are always considered therapy regardless of the provider type and will require the aforementioned therapy modifiers (GN, GO, and GP) and outpatient occupational or physical therapy assistant, modifiers if applicable be included on the claim line in order to be eligible for reimbursement.

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

- Modifier GT designates services performed via interactive audio and video telecommunication systems and will be reimbursed with codes in alignment with CMS.

- Modifier GY designates that an Item or service is statutorily excluded or does not meet the definition of any Medicare benefit. Modifier GY is therefore not eligible for reimbursement.

- Lower Limb Prosthesis are required to be filed with appropriate functional modifiers K0-K4.

- Modifier KF designates an item as an FDA Class III device. External defibrillators and Osteogenesis stimulators are not eligible for reimbursement when billed without the KF modifier.

- Modifier GZ designates that an item or service is expected to deny as not reasonable or necessary. Modifier GZ is therefore not eligible for reimbursement.

- 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.

- Power wheelchair(s) are not eligible for reimbursement when billed with modifier NU (new equipment) or modifier UE (used equipment).

- 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), Blue Cross NC follows CMS guidance.

- Modifier RA – Replacement of a DME item.

- Modifier RR – DME rental. Capped rental DME must be appended with Modifier RR.

- Modifier PI - Positron emission tomography (PET) or PET/computed tomography (CT) to inform the initial treatment strategy of tumors that are biopsy proven or strongly suspected of being cancerous based on other diagnostic testing. Initial PET services reported for oncology are only eligible for reimbursement when submitted with Modifier PI.

- Modifier Q0 – Investigational clinical services related to an approved clinical research study are only eligible for reimbursement when submitted with Modifier Q0.

- Modifier SL- State supplied vaccine. Vaccines and toxoids provided at no cost by the state are not eligible for reimbursement. However, the administration of such vaccines and toxoids may be eligible for reimbursement. See "Immunization Guidelines" reimbursement policy.

- 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.

- 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.

- Portable x-ray transportation services must be appended with one of the x-ray transportation modifiers, including: UN, UP, UQ, UR, or US in order to be eligible for reimbursement. Payment may be adjusted based on the number of patients served, consistent with CMS policy. Set up of portable x-Ray equipment (Q0092) is only eligible for reimbursement when transportation of portable x-ray equipment (R0070 or R0075) has also been billed and paid for on the same date of service.
    - X-ray transportation modifiers:
        - UN - two patients served
        - UP - three patients served
        - UQ - four patients served
        - UR - five patients served
        - US - six patients served

- Combined Diagnostic and Screening Mammography Performed on the Same Date

    - Consistent with CMS policy, specific modifiers are required when both a screening and diagnostic mammogram are performed on the same date of service. In this scenario, the diagnostic mammogram must be appended with Modifier GG in order to be eligible for reimbursement. Similarly, the screening mammogram must also be appended with Modifier 59, XE, XP, or XU otherwise, the screening mammogram will not be eligible for reimbursement.

- Anesthesia Modifiers

  Physicians must 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. Anesthesia modifiers should only be appended to anesthesia services. Additional service modifiers may be appropriate to use for anesthesia services, however when inappropriate service modifiers are appended to an anesthesia code, that service will not be eligible for reimbursement. (See also reimbursement policy titled "Anesthesia, Professional and Facility").

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

- Deceased Modifiers
  Services, supplies and/or devices are not reimbursable if modifier CA, PM, P6 or QL has been reported on a prior date of service.

- Professional and Technical Components

  Blue Cross utilizes CMS National Physician Fee Schedule (NPFS) Relative Value File, Professional Component (PC) and Technical Component (TC). Please reference the following table:

NPFS PC/TC Indicator	Description
0-Physician Service Codes	PC/TC doesn't apply. Modifiers 26 and TC cannot be used.
1-Diagnostic Test or Radiology Services	Usually have both a professional and technical component. Modifiers 26 and TC can be used.
2-Professional Component Only Codes	Describe standalone codes that incorporate the physician work assist with selected diagnostic tests. Other codes are used to describe the global test or technical component. Modifiers 26 and TC cannot be used with these codes
3-Technical Component Only Codes	Describe standalone codes for the technical component of diagnostic tests. Associated codes are used to describe the professional component of the diagnostic test. Modifiers 26 and TC cannot be used with these codes.
4-Global Test Only Codes	Describe standalone codes for which there are associated codes that identify the professional component of the test and then the technical component. Modifiers 26 and TC cannot be used with these codes.
5-Incident to Codes	Identifies codes that describe services that are incident to physician services when performed by support personal. Modifiers 26 and TC cannot be used with these codes.
6-Laboratory Physician Interpretation Codes	Identifies clinical laboratory codes for which physician interpretation can be made. Modifier TC cannot be used with these codes.
7- Private Practice Therapist's Service	Reimbursement may not occur if service is provided in an outpatient or inpatient hospital by an OT, PT, SLP in private practice.
8- Physician Interpretation Codes	Identifies the professional component of clinical laboratory codes where the physician interprets an abnormal smear in the inpatient hospital when separate payment may be made. This only applies to code 85060, and Modifier TC cannot be used with these codes.
9- Non applicable PC/TC	Concept of a professional/technical component does not apply to codes with this indicator.

Professional providers are not to report the TC modifier to a radiology procedure when done in the outpatient or inpatient facility setting as the facility will bill this. Technical components and Technical component only codes are not eligible for reimbursement in the outpatient or inpatient facility setting on a professional claim form.

At times, it may be necessary to transport x-ray equipment to the location of the member, such as the member's home or even an assisted living or nursing facility where the member resides, so that the x-ray service can be completed. In that case, the applicable revenue code for the transportation of the equipment will be required.

Global Only codes are those codes that represent the global service for which there are separate codes that represent the technical and professional components. These codes are not to be appended with Modifiers 26 or TC. Blue Cross NC will not provide reimbursement for Global Only codes with Modifiers 26 or TC. Blue Cross NC will not reimburse physicians for services with a PC/TC Indicator 4, when rendered in a facility setting.

Rationale

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

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see the Blue Cross NC web site at www.bcbsnc.com.

Reimbursement for a procedure code/modifier combination will be considered only when the modifier has been used appropriately in accordance with correct coding principles defined in ICD-10, HCPCS and CPT.

Related policy

Anesthesia, Professional and Facility

Bundling Guidelines

Co-Surgeon, Assistant Surgeon, Team Surgeon, and Assistant-at-Surgery

Global Surgery

Immunization Guidelines

Maximum Units of Service

Split Surgical Package

References

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

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

Centers for Medicare & Medicaid Services, CMS Manual System, and Medicare Claims Processing Manual 100-04

American Medical Association, Current Procedural Terminology (CPT®)

Centers for Disease Control and Prevention, International Classification of Diseases, 10th Revision

Healthcare Common Procedure Coding System

History

6/1/2022	New policy developed. Medical Director approved. **Notification on 3/31/2022 for effective date 6/1/2022**. (eel)
12/31/2022	Routine Policy Review. Minor Revisions only. (cjw)
5/2/2023	Clarification to AX modifier, coding update. Modifier 52 updated to include CMS guidance. **Notification on 3/1/2023 for effective 5/2/2023.** (cjw)
5/16/2023	Multiple updates to Level II HCPCS/National Modifiers. Medical Director approved. **Notification on 5/16/2023 for effective date 7/18/2023**. (tlc)
7/18/2023	Added Erythropoiesis stimulating agent (ESA), GY, GZ, PI, and Q0 Modifiers. Added language regarding deceased modifiers and set up of portable x-ray equipment. Medical Director approved. **Notification on 7/18/2023 for effective date 9/18/2023.** (tlc)

Application

These reimbursement requirements apply to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services.

This policy relates only to the services or supplies described herein. Please refer to the Member's Evidence of Coverage (EOC) 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 policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.