In the event of a conflict between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. Plan documents include but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents.

In the event of a conflict between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern.

Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative workup. The billing office is expected to submit claims for services rendered using valid codes from the Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT Assistant, Healthcare Common Procedure Coding System (HCPCS), National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Coding Initiative (CCI) table edits and other CMS guidelines. Claims are subject to the code auditing protocols for services/procedures billed.

Modifier Reference Guideline

Policy Number: CPCP023

Version 4.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: 11/27/2018

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Description

This policy serves as a general reference guidelines for appending modifiers to the appropriate procedure codes when submitting claims for reimbursement. This policy serves as a general reference guideline for appending modifiers to the appropriate procedure codes when submitting claims for reimbursement. This policy is not intended to impact care decisions or medical practice. The American Medical Associate (AMA) Current Procedural Terminology (CPT) manual and Centers for Medicare and Medicaid Services (CMC) defines modifiers that may be appended to CPT/HCPCS codes to provide additional information about the services rendered. For the purposes of this policy, a modifier should be appended to denote additional information about the services rendered. Modifiers consist of two numeric or alphanumeric characters. All valid CPT and HCPCS modifiers are accepted into the claims processing system used to review claims submitted. Several modifiers have claims logic that may impact claim reimbursement and are outlined in this policy.

Reimbursement Information:

A modifier may be appended to CPT/ HCPCS code(s) if the service or procedure is clinically supported by the use of the modifier. A claim should be submitted with the correct modifier-to-procedure code combination. Modifiers should not be appended to a CPT/HCPCS code to omit a National Correct Coding Initiative (NCCI) Procedure to procedure (PTP) edit if the service or procedure is not clinically supported for the use of the modifier. Claim submissions may be denied if a claim contains an inappropriate modifier-to-procedure code combination. In this case, a corrected claim submission with the correct modifier-to-procedure code combination will be necessary to be considered for reimbursement. Medical records or other documentation should accompany the claim to be reviewed to ensure the appropriateness of claim reimbursement.

Reimbursement Information (cont'):

If billing with more than one modifier, list the modifier that will impact reimbursement first.

The modifiers listed below may appear in some of the material on the applicable state plan provider website. The following is not an all-inclusive list and modifiers may be added or removed with appropriate notice.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
22	Increased Procedural Services	Should be appended to surgical procedure codes with supporting documentation to justify the unusual service: • If documentation supports sufficient difficulty/complexity to warrant additional payment for a procedure submitted with Modifier 22. Otherwise, no additional payment is allowed. • A provider is allowed one appeal if the initial request for recognition of Modifier 22 is denied.
24	Unrelated Evaluation and Management (E/M) service by the same physician or other qualified health care professional during a postoperative period	The physician or other qualified health care professional 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. This circumstance may be reported by appending modifier 24 to the appropriate level of E/M service.
25	Significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service	records should reflect the significant, separately identifiable service. It may be necessary 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 other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
26	Professional component	The total service for some procedures include both a professional component and a technical component. Codes within the Radiology, Lab/Pathology and Medicine sections of the CPT codebook have technical and professional components of the total service. Modifier 26 denotes the professional services for lab and radiological services. Modifier TC denotes technical component for lab and radiological services. Append the modifiers to the appropriate lab, radiological, or medicine procedures only. When a provider performs both the technical and professional service for a lab or radiological procedure, the total service is reported without a modifier. The professional and technical components should not be reported individually when both components are performed by the same provider.
TC	Technical Component	
33	Preventive services	When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.
50	Bilateral procedure	Append modifier to the appropriate 5-digit code for procedures that can be performed bilaterally at the same session.
52	Reduced services	Under specific circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
57	Decision for surgery	This modifier is to be appended to the appropriate E/M code to denote that it resulted in the initial decision to perform a major surgical procedure. The modifier will be allowed only when appended to an E/M code reported for either one day prior OR same day as a major (90 day global) surgical procedure. Refer to CMS guidelines for global days.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
58	Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period	Append modifier to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure.
59 I. **XE** II. **XP** III. **XS** IV. **XU**	Distinct procedural service	Allowed only when modifier appended to procedure or service that are not routinely reported together. Documentation must support a different session, different procedure or surgery, different site or separate organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same individual. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Refer to the current CPT guidelines for additional information. I. XE: Separate encounter- Service that is distinct because it occurred during a separate encounter. Refer to CMS guidelines. II. XP: Separate Practitioner- Service that is distinct because it was performed by a different practitioner. Refer to CMS guidelines. III. XS: Separate structure- Service that is distinct because it was performed on a separate organ/structure. Refer to CMS guidelines. IV. XU: Unusual non-overlapping service- Use of service that is distinct because it does not overlap usual components of the main service. Refer to CMS guidelines.
62	Two surgeons	Two surgeons working together as primary surgeons. Both surgeons should submit this modifier on only those services where they are acting as primary surgeons. Each surgeon should report his/her operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, Physicians acting as co-surgeons cannot bill as assistants. Separate code(s) may also be reported with modifier 62 added.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
66	Surgical team	More than two surgeons of different specialties working together under the "surgical team" concept. The surgeons should submit this modifier on only those services where they are acting as primary surgeon.
73	Prior Discontinued Ambulatory Surgical Center (ASC) or Outpatient Hospital	Append modifier when a surgical procedure or diagnostic procedure is discontinued due to extenuating circumstances or threaten the well-being of the patient, prior to anesthesia in the outpatient hospital or ASC only.
76	Repeat procedure or service by same physician or other qualified health care professional	Append modifier only when a procedure is repeated on the same date of service by the same physician or other qualified health care professional subsequent to the original procedure or service. This modifier should not be appended to an E/M service.
77	Repeat procedure by another physician or other qualified health care professional	Append modifier only when a basic procedure or service is repeated by another physician or other qualified health care professional subsequent to the original procedure or service. Procedure must be the same procedure. The procedure code should be submitted on the claim form once and then listed again on a separate line with the appropriate modifier appended. This modifier should not be appended to an E/M service.
78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period	Append modifier if needing to indicate another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure.
79	Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period	Indicate performance of a procedure or service during the postoperative period as unrelated to the original procedure. Not a repeat procedure on the same day.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
80 *See AS and SA Modifier below	Assistant surgeon (Physician)	Append modifier to those surgical procedures where an assistant surgeon is warranted. Physicians acting as assistants cannot bill as co-surgeons. Benefits will be derived based on the CMS designation for the assistant surgeon.
81 *See AS and SA Modifier below	Minimum assistant surgeon (Physician)	Append modifier to those surgical procedures where minimum surgical assistant services are warranted. Physicians acting as assistants cannot bill as co-surgeons. Benefits will be derived based on CMS designation for the assistant surgeon.
82 *See AS and SA Modifier below	Assistant surgeon (Physician) (When qualified resident surgeon not available)	Append modifiers to those surgical procedures where an assistant surgeon is warranted. The unavailability of a qualified resident surgeon is a prerequisite for use of the modifier to be appended. Physicians acting as assistants cannot bill as co-surgeons. Benefits will be derived based on CMS designation for the assistant surgeon.
****AS**	Physician assistant (PA), nurse practitioner (APN), licensed surgical assistant (LSA), or clinical nurse specialist services (CRNFA) for assistant at surgery	Append modifier when non-physician practitioners are assisting surgeons as a surgical assistant. The assistant surgeon provides more than ancillary services. • Physician should use when billing on behalf of a PA, APN, CRNFA or LSA including that providers National Provider Identification (NPI) number for services provided when the aforementioned providers are acting ONLY as an assistant during surgery. • PA's, APN's, CRNFA's or LSA's who are billing with their own NPI number should bill using modifier AS when assisting in a surgery.
****SA**	Nurse practitioner (NP) rendering service in collaboration with a physician for supervised NP services	• A supervising physician should use this modifier when billing on behalf of a PA or APN for non-surgical services. • PA's or APN's who are billing with their own NPI number should use Modifier SA when assisting with any other procedure that does not include surgery.
91	Repeat clinical diagnostic laboratory tests	• Should be used to report repeat lab tests or studies performed on the same day on the same member. Used only when the additional test results are to be obtained subsequent to the initial administration of the test(s) on the same day.

**Modifier AS and SA should be used by the supervising physician, when he/she is billing for services rendered by a Physician Assistant (PA), Advanced Practice Nurse (APN), Certified Registered Nurse First Assistant (CRNFA) or Licensed Surgical Assistant (LSA).

HCPCS modifiers should not be submitted on claims with Physician Quality Reporting Initiative (PQRI) CPT Category II codes. In this case, providers should ensure the appropriate billing of Category II modifiers.

For additional information regarding modifier reimbursement percentages, participating providers should refer to the plan's provider website or contact a Network Representative.

References:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

American Medical Association, Current Procedural Terminology (CPT®)

American Medical Association, 2018 HCPCS Level II, Professional Edition

Policy Update History:

Update Date	Description
11/27/2018	New policy