If a conflict arises between a Clinical Payment and Coding Policy (CPCP) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP 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. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from 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), ICD-10 CM and PCS, National Drug Codes ("ND), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Modifier Reference Guideline

Policy Number: CPCP023

Version 2.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: March 31, 2021

Plan Effective Date: July 15, 2021

Description

This policy serves as a general reference claim submission guideline for appending modifiers to the appropriate procedure codes. This policy is not intended to impact care decisions or medical practice. The American Medical Association (AMA) Current Procedural Terminology (CPT) manual and The Centers for Medicare & Medicaid Services (CMS) 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 service 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:

Modifiers may be appended to CPT/ HCPCS code(s) if the service or procedure is clinically supported for use of modifiers. A claim should be submitted with the correct modifier-to-procedure code combination. Modifiers should not be appended to a CPT/HCPCS code(s) to circumvent a National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edit if the service or procedure is not clinically supported for the use of a 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 ensure appropriateness of claim reimbursement. The plan reserves the right to request supporting documentation. Claims may be reviewed on a case by case basis.

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's provider website. The following is not an all-inclusive list and modifiers may be added or removed with appropriate notice. The inclusion of a modifier below does not guarantee reimbursement.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER

22	Increased Procedural Services	Append modifier to indicate a service or procedure provided is significantly greater than that usually required.
		• Documentation should support substantial additional work and the reason for the additional work which may include:
		  ○ Time
		  ○ Severity of patient's condition
		  ○ Increased intensity
		  ○ Technical difficulty of procedure
		• Modifier 22 is ineligible for reimbursement for an E/M service.
		• Should be submitted with supporting documentation.

24	Unrelated Evaluation and Management (E/M) service by the same physician or other qualified health care professional during a postoperative period	Append modifier if an unrelated E/M service by the same physician or other qualified health care professional during a post-operative period occurs. • Modifier 24 is applied to two code sets, E/M services and general ophthalmological services for eye examinations.
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	Append modifier to a significant, separately identifiable E/M service by the same physician or other health care professional on the same day of a procedure or other service. • A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.
26	Professional component	Append modifier only when the professional component is billed when certain services combine both the professional and technical services in one procedure code.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER

		• Requires a separate interpretation and report.
		• Modifier 26 denotes the professional component for the following types of service, such as:
		  • Lab
		  • Radiology
		  • Radiation Therapy

TC	Technical Component	Append modifier only when the technical component is billed when certain services combine both the professional and technical services in one procedure code.
		• Modifier TC denotes the technical component for the following types of service, such as:
		  • Lab
		  • Radiology
		  • Radiation Therapy

33	Preventive services	Append to codes represented for evidence-based services in accordance with a US Preventive Services Task Force A and B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory). • Modifier 33 should be used for CPT codes representing preventive care services. • For additional information on Preventive Services, refer to CPCP006 Preventive Health Services.
50	Bilateral procedure	Modifier 50 is used to report bilateral procedures that are performed during the same service. The use of modifier 50 is applicable only to services and/or procedures performed on identical anatomic sites, aspects, or organs. • This modifier can be used for diagnostic, radiology, and surgical procedures. • Modifier 50 should not be used when the code descriptor indicates unilateral or bilateral and should not be used when RT and LT would be applicable to the services. • When using Modifier 50 to indicate a procedure was performed bilaterally, the modifiers LT (Left) and RT (Right) should not be billed on the same service line. Modifiers LT or RT should be used to identify which one of the paired organs were operated on. Billing procedures as two lines of service using the left (LT) and right (RT) modifiers is not the same as identifying the procedure with Modifier 50. • Modifier 50 should only be reported with one line with one unit of service.
51	Multiple procedures	Append modifier to an additional procedure or service when there are multiple procedures or services (not including E/M services) on the same day, during the same surgical session by the same individual.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
		• Should not be appended to add-on codes. • Should not be reported on all lines of service.
52	Reduced services	Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. • See modifier 73 or 74 for facility. • Append modifier for unusual reduced circumstances. • Should not be appended to report time-based codes. • Should not be used on E/M services.
53	Discontinued procedure	Under certain circumstances, the physician or other qualified healthcare professional may elect to terminate a surgical or diagnostic procedure due to circumstances that may threaten the well-being of the patient. • Append modifier for unusual discontinued circumstances. • Should not be used on E/M services. • Should not be used to report a cancellation of a procedure.
54	Surgical care only	Append modifier when a physician or other qualified healthcare professional performs a surgical procedure and another physician or other qualified healthcare professional performs the preoperative or postoperative management services. • Append modifier for the surgical care only.
55	Postoperative management only	Append modifier when a physician or other qualified healthcare professional performs a surgical procedure and another physician or other qualified healthcare professional performs the postoperative management services. • Append modifier for postoperative management services only. • Post-operative care should be reported with the same date of service as the surgical care. The date of service is the date the surgical care was rendered.
56	Preoperative management only	Append modifier when a physician or other qualified healthcare professional performs a surgical procedure and another physician or other qualified healthcare professional performs the preoperative management services. • Append modifier for preoperative management services only. • Should be reported with the date of service.
57	Decision for surgery	Append modifier to indicate an E/M service resulted in initial decision to perform surgery the day before a major surgical procedure or the day of the major surgical procedure.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
		• Append only to an E/M code as described above. • A major surgery has a 90-day post-operative surgery period (90 day global) and a preoperative surgery period that includes the day before surgery or the day of surgery.
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. • Append modifier when performing a second or related procedure during the postoperative period. • Should not be reported for unrelated procedures during the postoperative period.
59	Distinct procedural service	Under certain circumstances, it may be necessary to indicate a procedure or service was distinct or independent from other non-evaluation and management (E/M) services performed on the same day. • 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. • In order to bill this modifier, 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. • Additional modifiers should be evaluated to determine the appropriate usage such as XE, XS, XP and XU.
62	Two surgeons	Append modifier if two surgeons with different specialties are required to perform a specific procedure on the same patient during an operative session, both acting as primary surgeons. If co-surgeon acts as an assistant in the performance of an additional procedure, other than those reported with modifier 62, during the same surgical session, those services must be reported using different procedure codes with modifier 80 or 82, as appropriate. • Both surgeons should append modifier 62 on the submitted claim. • The procedure code and diagnosis code should be the same on the submitted claim. • For additional information, refer to CPCP009 Co-Surgeon/Team Surgeon Modifiers.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
66	Surgical team	Append modifier when more than two surgeons of different specialties are working together under the "surgical team" concept. • Should be submitted with supporting documentation that includes each surgeon's description of their performance during the procedure. • Both surgeons should submit this modifier on only those services where they are acting as primary surgeons. • For additional information, refer to CPCP009 Co-Surgeon/Team Surgeon Modifiers.
73	Discontinued out-patient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia	Append modifier when reporting a discontinued outpatient/hospital ambulatory surgical center (ASC) procedure prior to the administration of anesthesia due to extenuating circumstances or a threat to the well-being of a member.
74	Discontinued out-patient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia	Append modifier when a reporting termination of a surgical or diagnostic outpatient/hospital ambulatory surgical center (ASC) procedure after the administration of anesthesia or after the procedure was started due to extenuating circumstances or a threat to the well-being of a member.
76	Repeat procedure or service by same physician or other qualified health care professional	Append modifier only when a procedure or service 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. • The procedure code should be submitted on the claim form once and then listed again on a separate line with the appropriate modifier appended.
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. • 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 necessary, to indicate another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). • Should be used to identify a related procedure requiring a return trip to the operating/procedure room, on the same day as or within the postoperative period of a major or minor surgery. • Append if used to treat the member for complications resulting from the original surgery.
79	Unrelated procedure or service by the same physician or other	Append modifier to indicate the performance of a procedure or service during the postoperative period is unrelated to the original procedure.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
	qualified health care professional during the postoperative period	• Not a repeat procedure on the same day. • Modifier re-sets global period. A new post-operative period will begin when an unrelated procedure is billed.
80	Assistant surgeon	Append modifier to those surgical procedures where an assistant surgeon is warranted. • Physicians acting as assistants cannot bill as co-surgeons. • Physician is assisting at surgery.
81	Minimum assistant surgeon	Append modifier to those surgical procedures where minimum surgical assistant services are warranted. • Physician acting as an assistant that does not participate in the entire procedure; provides minimal assistance to the primary surgeon. • Physicians acting as assistants cannot bill as co-surgeons.
82	Assistant surgeon (When qualified resident surgeon not available)	Append modifiers to those surgical procedures where an assistant surgeon is warranted when a qualified resident surgeon is not available. Physicians acting as assistants cannot bill as co-surgeons.
91	Repeat clinical diagnostic laboratory tests	Append modifier to report repeat clinical diagnostic lab tests or studies performed on the same day on the same member to obtain subsequent test results. • Should not be submitted when a test is rerun to confirm the initial results due to an issue with the specimen, equipment or for any other reason when the one-time reportable result was all that was required.
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system	Append modifier to "CPT Codes That May Be Used for Synchronous Telemedicine Services" as defined in the CPT® codebook Appendix P. • Should only be used to indicate interactive real-time telemedicine services.
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	Append modifier when non-physician practitioners (PA, APN, CRNFA or LSA) are assisting surgeons as a surgical assistant. The assistant surgeon provides more than ancillary services. Append the modifier when the supervising physician is billing on behalf of a PA, APN, or CRNFA or LSA including that provider's National Provider Identification (NPI) number. Append modifier to PA, APN, CRNFA or LSA claim submissions when billing their own NPI.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
ER	Items and services furnished by a provider-based, off campus emergency department	Append modifier when items or services are furnished by a provider-based off-campus emergency department. • Should be appended with every claim line for outpatient hospital services furnished in an off-campus provider-based emergency department. • Provider-based off-campus emergency departments that meet the definition of a "dedicated emergency department", defined in 42 Code of Federal Regulations (CFR) 489.24 under the Emergency Medical Treatment and Labor Act (EMTALA) regulations are required to append modifier ER.
G0	Telehealth services for diagnosis, evaluation, or treatment of symptoms of an acute stroke	Append modifier to report telehealth services for diagnosis, evaluation, or treatment of systems of an acute stroke.
GQ	Via asynchronous telecommunications system	Append modifier to report use of an asynchronous telecommunications system. • Should only be used to indicate interactive telehealth services.
GT	Via interactive audio and video telecommunications system	Append modifier to report interactive audio and video telecommunications system. • Should only be used to indicate interactive telehealth services.
JW	Drug amount discarded/not administered to any patient	Append modifier to report the amount of unused drugs or biologicals from single use vials or single use packages that is discarded/not administered to the member.
NU	New equipment	Append modifier for new DME equipment.
PN	Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital	Append modifier for non-excepted items and services provided at an off-campus, outpatient, provider-based department of a hospital. • Append modifier on each claim line for non-excepted items and services, including but not limited to, separately payable drugs, clinical laboratory tests and therapy services.
PO	Excepted service provided at an off-campus, outpatient, provider-based department of a hospital	Append modifier for services, procedures and/or surgeries provided at off-campus provider-based outpatient departments. • Append modifier on each claim line for outpatient hospital services furnished in an off-campus provider-based department of a hospital.
PT	Colorectal cancer screening test; converted to diagnostic test or other procedure	Append modifier to report colorectal cancer screening services converted to a diagnostic test or other procedure.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
RR	Rental	Append modifier for DME rentals. • One unit of service is billed per monthly period unless classified as a daily rental.
SH	Second concurrently administered infusion therapy	Append modifier to report second concurrent administered infusion therapy.
SJ	Third or more concurrently administered infusion therapy	Services that are submitted with modifier SJ appended to them will **not** be reimbursed. This modifier denotes a third or more concurrent administered infusion therapy.
UE	Used durable medical equipment	Append modifier for used DME equipment.
XE	Separate encounter	In order to bill this modifier, documentation must support the service is distinct because it occurred during a separate encounter. • Refer to CMS guidelines.
XP	Separate Practitioner	In order to bill this modifier, documentation must support the service is distinct because it was performed by a different practitioner. • Refer to CMS guidelines.
XS	Separate structure	In order to bill this modifier, documentation must support the service is distinct because it was performed on a separate organ/structure. • Refer to CMS guidelines.
XU	Unusual non-overlapping service	In order to bill this modifier, documentation must support the use of a service is distinct because it does not overlap usual components of the main service. • Refer to CMS guidelines.

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:

CPCP006 Preventive Health Services

CPCP009 Co-Surgeon/Team Surgeon Modifiers

CPCP015 Multiple Procedures

CPCP019 Home Infusion

Medicare Claims Processing Manual Chapter 23 - Fee Schedule Administration and Coding Requirements

Policy Update History:

Approval Date	Description
11/27/2018	New policy
02/28/2020	Annual Review, Disclaimer Update
03/31/2021	Annual Review

Addendum: Blue Cross Blue Shield of Texas

Modifier **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).

MODIFIER	WHEN TO APPEND MODIFIER
SA	Append modifier to supervising physician claim submissions when billing on behalf of a PA or APN for non-surgical services. Append modifier to PA's or APN's claim submission when billing with their own NPI number for assisting with any other non-surgical procedures.