

# Modifier Payment Policy

## Policy

Modifiers are two-digit codes that may be added to the main procedure code. They are used to indicate that the procedure being reported has been altered by specific circumstances described by the modifier. The use of modifiers eliminates the need for separate procedure listings that may describe the modifying circumstances.

Note: The listing below does not represent the complete list of category-specific modifiers. For a complete list of modifiers and more information regarding the appropriate use of modifiers with individual codes, refer to the most current CPT and HCPCS guidelines.

## Reimbursement

The Plan will accept up to four modifiers per claim line. Per Medicare guidelines, the modifier that affects payment must be submitted first.

Reimbursements listed in this section will be paid only if all Plan procedures and referral requirements are followed.

The presence or absence of one of the following modifiers may affect claims payment or result in a claim denial.

**Click on one of the following hyperlinks to go directly to the corresponding modifier listing:**

- [Advance Beneficiary Notice of Noncoverage \(ABN\) modifiers](#)
- [Ambulance modifiers](#)
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### Advance Beneficiary Notice of Noncoverage (ABN) Modifiers

| Modifier | Description   |
|----------|---|
| GA       | Waiver of Liability Statement Issued as Required by Payer Policy. Used to report a required ABN was issued for a service and is on file. A copy of ABN does not have to be submitted but must be made available upon request. |
| GX       | Notice of Liability Issued, Voluntary Under Payer Policy. Used to report a voluntary ABN was issued for a service.  |
| GY       | Notice of Liability Not Issued, Not Required Under Payer Policy. Used to report that an ABN was not issued because item or service is statutorily   |

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|    | excluded or does not meet definition of any Medicare benefit.  |
| GZ | Item or Service Expected to Be Denied as Not Reasonable and Necessary. Used to report an ABN was not issued for a service. |

#### Ambulance origin and destination modifiers

Single-digit modifiers for ambulance transport are used in combination in reporting services to CMS. The first digit indicates the transport's place of origin, and the second digit indicates the destination.

| <b>Modifier</b>                       | <b>Description</b>  |
|---------------------------------------|---|
| D                                     | Diagnostic or therapeutic site other than P or H when these are used as origin codes  |
| E                                     | Residential, domiciliary, custodial facility (other than 1819 facility)   |
| G                                     | Hospital-based ESRD/dialysis facility (hospital or hospital related)  |
| H                                     | Hospital  |
| I                                     | Site of transfer (for example, airport or helicopter pad) between types of ambulance  |
| J                                     | Freestanding/Non-hospital based ESRD/dialysis facility  |
| N                                     | Skilled nursing facility (1819 facility)  |
| P                                     | Physician's office (includes HMO non-hospital facility, clinic, etc.)   |
| R                                     | Residence   |
| S                                     | Scene of accident or acute event  |
| X                                     | Intermediate stop at physician's office on way to hospital (includes HMO non-hospital facility, clinic, etc.) (destination code only) |
| <b>Other Ambulance Modifier Codes</b> |   |
| CR                                    | Catastrophe/disaster related  |
| GA                                    | Non-covered service, waiver of liability on file  |
| GM                                    | Multiple patients on one ambulance trip   |
| GW                                    | Service unrelated to hospice patient's terminal condition   |
| GY                                    | Statutorily excluded service  |
| GZ                                    | Service not reasonable and necessary  |
| QJ                                    | Incarcerated patient responsible to pay   |
| QL                                    | Patient pronounced dead after ambulance called/dispatched   |
| QM                                    | Ambulance service provided under arrangement by a provider of   |

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|    | services (institutional-based providers)   |
| QN | Ambulance service furnished directly by a provider of services (institutional-based providers) |
| TQ | Basic Life Support transport provided by a volunteer ambulance service                         |

#### Anatomic modifiers

Append to a service that is performed on the hands, feet, eyelids, coronary artery, or left and right side of the body.

#### Side of Body modifiers

| Modifier | Description  |
|----------|--|
| LT       | Left side (used to identify procedures performed on the left side of the body)   |
| RT       | Right side (used to identify procedures performed on the right side of the body) |

#### Eyelid modifiers

| Modifier | Description         |
|----------|---------------------|
| E1       | Upper left, eyelid  |
| E2       | Lower left, eyelid  |
| E3       | Upper right, eyelid |
| E4       | Lower right, eyelid |

#### Hand modifiers

| Modifier | Description              |
|----------|--------------------------|
| FA       | Left hand, thumb         |
| F1       | Left hand, second digit  |
| F2       | Left hand, third digit   |
| F3       | Left hand, fourth digit  |
| F4       | Left hand, fifth digit   |
| F5       | Right hand, thumb        |
| F6       | Right hand, second digit |
| F7       | Right hand, third digit  |
| F8       | Right hand, fourth digit |
| F9       | Right hand, fifth digit  |

#### Feet modifiers

| Modifier | Description             |
|----------|-------------------------|
| TA       | Left foot, great toe    |
| T1       | Left foot, second digit |
| T2       | Left foot, third digit  |

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| T3 | Left foot, fourth digit  |
| T4 | Left foot, fifth digit   |
| T5 | Right foot, great toe    |
| T6 | Right foot, second digit |
| T7 | Right foot, third digit  |
| T8 | Right foot, fourth digit |
| T9 | Right foot, fifth digit  |

#### Coronary artery modifiers

| Modifier | Description                              |
|----------|--|
| LC       | Left circumflex coronary artery          |
| LD       | Left anterior descending coronary artery |
| LM       | Left main coronary artery                |
| RC       | Right coronary artery                    |

#### Anesthesia modifiers

Anesthesia services require one of the following modifiers: See the Provider Manual, section 4C – Billing and payment guidelines for professional claims for detailed information on billing for anesthesia services.

| Modifier  | Description  | Impact to Reimbursement  |
|---|--|--|
| AA  | Anesthesia services performed personally by anesthesiologist.  |  |
| AD  | Medical supervision by a physician: More than four concurrent anesthesia procedures.                       | Reimbursement will be additional three base units per procedure. |
| QK  | Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals. | Reimbursement will be at 50% of the allowable amount.            |
| QS  | Monitored anesthesia care services. The QS modifier must be submitted with modifiers –G8 and –G9.          | Reimbursement will be at 50% of the allowable amount.            |
| QX  | CRNA service: With medical direction by a physician.   |  |
| QY  | Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist.             | Reimbursement will be at 50% of the allowable amount.            |
| QZ  | CRNA service: Without medical direction by physician.  | Reimbursement per Medicare guidelines.                           |
| Note: The reporting of physical status modifiers or qualifying circumstances (99100 – 99140) do not affect reimbursement. |  |  |

#### Durable medical equipment (DME) modifiers

| Modifier | Description |
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| MS | Submit with HCPCS DME code to indicate six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty |
| NU | Submit with HCPCS DME code to indicate new durable medical equipment  |
| RR | Submit with HCPCS DME code to indicate a rental   |
| UE | Submit with HCPCS DME code to indicate used durable medical equipment   |

#### Level 1 CPT-4 Modifiers

The only Level 1 CPT-4 modifiers approved for hospital/facility use are 25, 27, 50, 52, 58, 59, 73, 74, 76, 77, 78, 79 and 91.

| Modifier | Name  | When to Use   | Impact to Reimbursement |
|----------|---|---|-------------------------|
| 21       | Prolonged evaluation and management services  | When the service provided is prolonged or greater than that usually required for the highest level of evaluation and management service. If modifier 21 is used with low or moderate complexity evaluation and management services (99201, 99202, 99203, 99204), the claim will be rejected due to an invalid modifier/procedure combination.   |                         |
| 22       | Increased procedural services   | When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, and severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service. |                         |
| 23       | Unusual anesthesia  | To indicate a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia.<br>• The Plan may require medical notes.  |                         |
| 24       | Unrelated evaluation and management service by the same physician during a postoperative period | To indicate that an E/M service was performed during a postoperative period for a reason unrelated to the original procedure.<br>• Attach supporting documentation.   |                         |
| 25       | Significant,  | To indicate that on the day a   | Reimbursement will be   |

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|    | separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service | procedure identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service in addition to the other services provided or the preoperative and postoperative care associated with that procedure. | made for a preventive code with a problem focused code when modifier -25 is applied to the problem-focused code. Reimbursement for the preventive service will be made at 100% of the contracted rate, and reimbursement for the problem focused service will be made at 50% of the contracted rate. This should only occur when a significant abnormality or pre-existing condition is addressed and additional work is required to perform the key components of a problem focused E&M service and services should be submitted on the same claim. Members have no copayment and/or deductible for routine physical exams. Senior Plan Members will be responsible for a copayment and/or deductible when a problem-focused code with modifier -25 is included on the claim. Therefore, the appropriate use of modifier -25 is critical since it will be transparent to members. Beginning October 1, 2014, the Plan will not calculate a copayment and/or deductible for E&M codes submitted with modifier -25 when billed with annual preventive services for members enrolled in a Commercial plan. Those services coded with modifier -25 will be regularly reviewed for coding accuracy. |
| 26 | Professional component  | To indicate that the billed service is for the professional component for   |   |

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|    |  | radiology, pathology or cardiology. The acceptance of modifier 26 with a procedure is based on CMS guidelines.  |  |
| 27 | Multiple outpatient hospital E/M encounters on the same date | Report the use of hospital resources for separate E/M services: <ul style="list-style-type: none"> <li>• provided to the same patient</li> <li>• by the same or different provider(s)</li> <li>• in more than one outpatient hospital setting</li> <li>• on the same date of service</li> </ul> Modifier 27 is not allowed with radiology or laboratory procedures.   |  |
| 32 | Mandated services  | To indicate services are related to mandated consultation and/or related services (e.g., third party payer, governmental, legislative or regulatory requirement)  |  |
| 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 adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used. |  |
| 47 | Anesthesia by surgeon  | Regional or general anesthesia provided by the surgeon may be reported by adding the modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures 00100–01999. <ul style="list-style-type: none"> <li>• Reporting of this modifier is for informational purposes only.</li> </ul> This service is not covered by the Plan.                       |  |
| 50 | Bilateral procedure  | Surgical: To indicate bilateral procedures performed at the same operative session. Modifier 50 is used with surgical procedures (CPT-4 codes 10040–69990). Submit the procedure code on a single claim line with modifier 50 with “1” unit. Do not use this modifier to report surgical  | Reimbursement for bilateral services is determined by the Medicare Physician Fee Schedule Database (MPFSD), which is located in the Provider Manual. |

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|    |                        | <p>procedures already identified by their description as “bilateral.”</p> <p>Radiology: Modifier 50 should not be used with radiology procedures that describe bilateral joint films.</p> <p>When reporting (bilateral) radiological services you should use the RT and LT modifiers. Radiological services should be billed on two claim lines with the RT and LT modifier and one unit on each line. Do not use the RT and LT modifier to report services already identified as bilateral by definition.</p> |  |
| 51 | Multiple procedures    | <p>When the same provider performs multiple procedures other than evaluation and management services at the same session, the primary procedure or service should be reported as listed. The additional procedure or service should be identified by adding the modifier 51 to its code. This modifier should not be appended to designated add-on codes.</p>  | <p>The use of modifier 51 will reduce reimbursement by 50% of the billing physician’s or facility’s contracted rate.</p> |
| 52 | Reduced services       | <p>To indicate that a service or procedure is partially reduced or eliminated at the physician’s discretion. The reduced or eliminated procedure or service should be identified by adding the modifier –52 to its code.</p> <p>This modifier is also recognized for radiology services.</p>   | <p>Reimbursement for reduced surgical services will be at 50% of the billing physician’s contracted rate.</p>            |
| 53 | Discontinued procedure | <p>To indicate that the physician has elected to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.</p>  | <p>Reimbursement will be reduced by 50% of the billing physician’s contracted rate.</p>                                  |
| 54 | Surgical care only     | <p>When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding the modifier 54 to the usual procedure number.</p>  | <p>Surgical only services will be reimbursed at 70% of the billing physician’s contracted rate.</p>                      |



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| 55 | Postoperative  | <p>When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier –55 to the usual procedure number.</p> <p>Attach supporting documentation.</p>   | Postoperative management services will be reimbursed at 20% of the billing physician's contracted rate.   |
| 56 | Preoperative   | <p>When one physician performs the preoperative care and evaluation management only and another physician performs the surgical procedure, the pre- operative component may be identified by adding the modifier 56 to the usual procedure number. Do not attach modifier 56 to an E/M code.</p>  | Preoperative management services will be reimbursed at 10% of the billing physician's contracted rate.  |
| 57 | Decision for surgery   | <p>To indicate an evaluation and management service that resulted in the initial decision to perform surgery. CPT codes for use with the modifier 57 are 92002-92014 and 99201-99499. Use this modifier only in cases in which the decision for surgery was made during the preoperative period of a surgical procedure with a 90-day postoperative period (i.e., major surgery).</p>   |   |
| 58 | Staged or related procedure or service by the same physician during the postoperative period | <p>To indicate that the performance of a procedure or service during the postoperative period was:</p> <ol style="list-style-type: none"> <li>1. Prospectively planned with the original procedure (staged)</li> <li>2. More extensive than the original procedure</li> <li>3. For therapy following a diagnostic surgical procedure</li> </ol> <p>Note: This modifier is not used to report the treatment of a problem that requires a return to the operating room.</p> <p>See modifier 78.</p> |   |
| 59 | Distinct procedural service  | <p>To indicate that a procedure or service was distinct or independent from other services performed on the same day other than evaluation and management services. Modifier 59 is used to identify procedures/services that are not normally reported together but are appropriate under the</p>   | The first procedure may be reimbursed at 100% of the billing physician's contracted rate. All subsequent procedures will be reviewed and payment may be affected. |

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|    |   | <p>circumstances. Use only if a more descriptive modifier is not available, and the use of modifier 59 best explains the circumstances.</p> <p>Attach supporting documentation.</p> <p>This modifier is also recognized for radiology services. Reimbursement for radiology services is not reduced.</p>  | <p>This modifier is also recognized for radiology services. Reimbursement for radiology services is not reduced.</p>  |
| 62 | Two surgeons                                  | <p>When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding the modifier 62 to the procedure code and any associated add-on code(s) for that procedure for 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 procedures, are performed during the same surgical session, separate code(s) may also be reported without the modifier 62 added.</p> <p>Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier '-80' or modifier 82 added, as appropriate.</p> |   |
| 63 | Procedure performed on infants less than 4 kg | <p>Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance may be reported by adding the modifier 63 to the procedure code.</p> <p>Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20000-69999 code series. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections of the Provider Manual.</p>  | <ol style="list-style-type: none"> <li>1. Claims billed with modifier 63 will require the submission of operative notes if additional reimbursement is requested.</li> <li>2. Notes will be reviewed by a Medical Director to determine appropriateness and amount of reimbursement, which may equal up to 25% of charges above what would be considered normal for a given procedure.</li> </ol> |

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| 66 | Surgical team  | When highly complex procedures requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, and various types of complex equipment are carried out under the surgical team concept.   | Each physician will receive 62.5% of the billing physician's contracted rate. |
| 73 | Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia | <p>Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of the modifier 73.</p> <p>Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.</p> | Reimbursement will be reduced by 50% of the facility's contracted rate.       |
| 74 | Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia        | <p>Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc.). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of the modifier 74.</p> <p>Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.</p>  |   |
| 76 | Repeat procedure   | To indicate that a procedure or  |   |

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|    |   | <p>service was repeated subsequent to the original procedure or service by same physician.</p> <ul style="list-style-type: none"> <li>• This modifier is also recognized for radiology services.</li> </ul>          |  |
| 77 | Repeat procedure by another physician   | <p>To indicate that a basic procedure or service performed by another physician had to be repeated.</p> <ul style="list-style-type: none"> <li>• This modifier is also recognized for radiology services.</li> </ul> |  |
| 78 | Return to the operating room for a related procedure during the postoperative period. | To indicate that another procedure was performed during the postoperative period of the initial procedure.   | Reimbursement will be at 70% of the billing physician's contracted rate.   |
| 79 | Unrelated procedure or service - postoperative period                                 | To indicate that the performance of a procedure or service by the same physician during the post-operative period was unrelated to the original procedure.   | E/M services will not be reimbursed during postoperative period.   |
| 80 | Assistant surgeon   | To identify surgical assistant services, attach modifier to appropriate Surgical CPT-4 code.   | <ol style="list-style-type: none"> <li>1. Charges need to be submitted on a separate claim.</li> <li>2. Automatic edits are utilized on assistant surgeon claims to determine clinical necessity of assistant surgeon for billed procedure.</li> <li>3. The claim will be paid at 16% of the assistant surgeon's contracted rate.</li> </ol> |
| 81 | Minimum Assistant Surgeon   | Minimum surgical assistant services are identified by adding the modifier 81 to the usual procedure number. Use modifier 81 when the assistant-at-surgery is not present for the entire procedure.                   | <ol style="list-style-type: none"> <li>1. Charges need to be submitted on a separate claim.</li> <li>2. Automatic edits are utilized on assistant surgeon claims to determine clinical necessity of assistant surgeon for billed procedure.</li> <li>3. The claim will be paid at 16% of the assistant surgeon's contracted rate.</li> </ol> |
| 82 | Assistant surgeon when qualified  | To identify the unavailability of a qualified resident surgeon, attach   | 1. Charges need to be submitted on a separate  |

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|    | resident surgeon not available             | modifier to appropriate Surgical CPT-4 code.  | claim.<br>2. Automatic edits are utilized on assistant surgeon claims to determine clinical necessity of assistant surgeon for billed procedure.<br>3. The claim will be paid at 16% of the assistant surgeon's contracted rate. |
| 91 | Repeat Clinical Diagnostic Laboratory Test | In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of the modifier 91.<br><br>Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient. |  |

Level II HCPCS modifiers

| Modifier | Name   | When to Use  | Impact to Reimbursement  |
|----------|--|--|--|
| AS       | Physician assistant, nurse practitioner or clinical nurse specialist services for assistant-at-surgery | Use this modifier to indicate a physician assistant or nurse practitioner assisted at surgery. | 1. Charges need to be submitted on a separate claim.<br>2. Automatic edits are utilized on assistant surgeon claims to determine clinical necessity of assistant surgeon for billed procedure.<br>3. The claim will be paid at 16% of the assistant surgeon's contracted |

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|    |  |  | rate.  |
| Q5 | Service performed by a substitute physician under a reciprocal billing arrangement | Use this modifier when services are furnished by a substitute physician under a reciprocal billing arrangement. This modifier has no effect on payment.  |  |
| Q6 | Service furnished by a locum tenens physician                                      | Use this modifier when services are furnished by a locum tenens physician. This modifier has no effect on payment.   |  |
| SA | Nurse practitioner rendering service in collaboration with a physician             | Use this modifier when a nurse practitioner is rendering service in collaboration with a physician.  |  |
| SB | Nurse Midwife  | Use this modifier to report professional services provided independently and use reduced service modifiers to report when they have not provided all the services covered by a global allowance. Ancillary services should not be reported with the SB modifier. |  |
| SL | State supplied vaccine   | Use this modifier to indicate the vaccine is state supplied.   | The Plan does not reimburse for state supplied vaccines.                     |
| TC | Technical Component  | Use to report only the technical component.  | Payment is based solely on the technical value of each individual procedure. |

### Therapy Modifiers

Used to identify type of therapy service and level of functional impairment

Outpatient Therapy Code Modifiers – Identify discipline of plan of care under which service is delivered.

| Modifier | Description   |
|----------|---|
| GN       | Services delivered under an outpatient speech language pathology plan of care |
| GO       | Services delivered under an outpatient occupational therapy plan of care      |
| GP       | Services delivered under an outpatient physical therapy plan of care          |
| KX       | Used to indicate the services rendered are medically necessary                |

Therapy Functional Modifiers – Used in conjunction with function related G series codes for physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) to indicate severity/complexity of beneficiary's percentage of functional impairment as determined by clinician furnishing therapy services.

| Modifier | Description                               |
|----------|---|
| CH       | 0 percent impaired, limited or restricted |

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| CI | At least 1 percent but less than 20 percent impaired, limited or restricted   |
| CJ | At least 1 percent but less than 20 percent impaired, limited or restricted   |
| CK | At least 40 percent but less than 60 percent impaired, limited or restricted  |
| CL | At least 60 percent but less than 80 percent impaired, limited or restricted  |
| CM | At least 80 percent but less than 100 percent impaired, limited or restricted |
| CN | 100 percent impaired, limited or restricted                                   |

## Billing/coding guidelines

### Modifier KX:

The KX modifier is a multipurpose, informational modifier and can be used to identify services for transgender, ambiguous genitalia, and hermaphrodite beneficiaries in addition to its other existing uses. Physicians and non-physician practitioners should use modifier KX with procedure codes that are gender specific in the particular cases of transgender, ambiguous genitalia, and hermaphrodite beneficiaries.

### Modifier 22:

The Plan requires documentation when claims are submitted with modifier 22 (unusual procedural services). Claims submitted without additional documentation are not considered for additional compensation. Clinical documentation must indicate one of the following:

- Excessive blood loss for the particular procedure performed
- Extensive, well-documented adhesions present with an abdominal surgery and requiring a minimum of 45 minutes to lyse.
- Presence of an excessively large surgical specimen (tumor).
- Trauma so extensive that the particular procedure and complication is not billed as separate and distinct procedures themselves.
- Other pathologies, tumors, and malformations that increase the complexity of the procedure.
- Extended anesthesia is identified (anesthesia record must be submitted).

Do not submit modifier 22 if you are reporting any of the following:

- Increased complexity due to a surgeon's choice of approach.
- Describing a re-operation.
- Describing a weight reduction surgery.
- Describing the use of robotic assistance.
- An unspecified procedure code.

### Modifier 25:

The American Medical Association's CPT Coding Manual describes the use of modifier 25 as "the physician may need to indicate that on the day that 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".

### Modifier 33:

The Plan accepts and recognizes the use of modifier 33 when billed with services on the U.S. Preventive Services Task Force List that have an A or B rating.

The American Medical Association created this modifier to allow providers to identify a preventive service for which patient cost sharing does not apply under the Patient Protection and Affordable Care Act, which prohibits patient cost sharing for non-grandfathered plans.

Modifier 33 is appropriate to use with a CPT code that is a diagnostic/treatment service being performed as a preventive service. This modifier has no impact on claims payment.

### Modifier 59 and subsets:

**Modifier 59 subsets:** CMS has established four new HCPCS modifiers to define subsets of modifier 59, used to define a “Distinct Procedural Service”. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. For more information, refer to CMS guidelines.

The Plan accepts either a modifier 59 or a more selective modifier as correct coding, and the compensation impact currently applied to modifier 59 will be applied to modifiers XE, XP, XS, and XU.

## Place of service

This policy applies to services rendered in all settings.

## Policy history

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| Origination date:          | 07/01/2016   |
| Previous revision date(s): | N/A  |
| Connection date & details: | September 2016 – Introduced policy.<br>January 2018 – Annual Review, no updates.<br>April 2018 – Clarified reimbursement of AS modifier. |

*The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.*