BlueCross BlueShield of Alabama

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MODIFIERS

A Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) modifier is a two-character (alpha and/or numeric) code appended to a CPT/HCPCS procedure code to clarify the services or procedures being billed. The modifier indicates that the service or procedure performed has been altered by some specific circumstance but not changed in its definition or code.

Modifiers are grouped into two levels

- **Level I** – Modifiers and descriptors that are copyrighted by the American Medical Association.
- L**evel II** – Modifiers and descriptors that are approved and maintained by the Alphanumeric Editorial Panel.

Understanding how and when to use a CPT/HCPCS modifier is vital for proper reporting of medical services and procedures. Blue Cross and Blue Shield of Alabama will accept modifiers that comply with the Health Insurance Portability and Accountability Act (HIPAA) legislation. Many modifiers are considered "informational only" and do not affect the processing of the claim or reimbursement. The lack of modifiers or the improper use of modifiers can result in claims processing delays or claims denials.

There are modifiers that Blue Cross does not utilize in claim processing or pricing. The use of modifiers is subject to any Blue Cross and Blue Shield of Alabama Policy that has been established relative to these modifiers and should only be used when appropriate. Blue Cross will consider and review additional modifiers. Providers will be notified when any decision is made relative to the adoption of any additional modifiers.

Blue Cross uses National Correct Coding Initiative (NCCI) edits developed by the Centers for Medicare & Medicaid Services (CMS) and fragmented coding edits designed by Blue Cross to promote correct coding methodologies. There are modifiers used in conjunction with some of the NCCI edits. These edits can be bypassed with modifier(s) only when the documentation supports the appropriate billing of both services in the specific clinical circumstance. It is not appropriate to use a modifier for the sole purpose of bypassing NCCI edits.

There are specific modifiers that may be appended to CMS NCCI Columns 1 and 2 edits and Mutually Exclusive edits as well as Blue Cross' edits when appropriate.

The following provides a guide to proper usage of modifiers that Blue Cross recognizes and utilizes in claim processing.

Modifier 22 – Increased Procedural Services

- This modifier is used to indicate that the service provided was substantially greater than typically required.
- The documentation must support the substantial additional work and the reason for the additional work.

Modifier 23 – Unusual Anesthesia

- This modifier is only recognized with anesthesia CPT code 01967 when epidural anesthesia is more than four hours.

Modifier 24 – Unrelated Evaluation and Management (E&M) Service by Same Physician During a Postoperative Period

- This modifier includes the same physician or physician with the same specialty and tax identification number during a postoperative period.
- This modifier is used when an E&M service was performed that was unrelated to the global surgery period.
- This modifier should only be appended to E&M codes and used during the global surgery period.
- Effective January 1, 2013 this modifier is used in conjunction with NCCI Edits.

Modifier 25 – Significant, E&M Service by the Same Physician on the Same Day of the Procedure or Other Services

- The purpose of this modifier is to indicate that a significant, separately identifiable E&M service was performed by the same physician or physician with the same physician specialty and tax identification number on the same day of a procedure or service.
- The E&M service has to be above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.
- This modifier should not be used to report an E&M service that resulted in a decision to perform surgery.
- The E&M service must meet the key components: history, examination and medical decision-making.
- Modifier 25 should only be appended to the E&M service on the same day as a minor procedure or service (procedures/services with 0- and 10-day global periods) or NCCI edits.

Modifier 26 – Professional Component

- Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the procedure code.
- The documentation should support that the physician performed the professional component of the procedure.

Modifier 32 – Mandated Services

Modifier 33 – Preventive Services

- When the primary purpose of the service is the delivery of an evidence-based service in accordance with a U.S. 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 Modifier 33 Preventive Service to the service.
- For separately reported services specifically identified as preventive, the modifier should not be used.
- View the Healthcare Reform Preventive Services Coding Guide on our website, **AlabamaBlue.com/providers**. Select "Healthcare Reform" under Provider Education and then looking for this guide under the Implementing Healthcare Reform heading.

Modifier 50 – Bilateral Procedure

- The purpose of this modifier is to report bilateral procedures performed at the same operative session by the same physician.
- Modifier 50 should only be applied to services and/or procedures performed on identical anatomic sites, aspects or organs.
- Modifier 50 should not be used when the code description indicates unilateral or bilateral.
- Bilateral modifiers must be submitted by repeating the appropriate code on two separate lines with modifier 50 appended to the second line.
- This modifier is used in conjunction with Blue Cross edits.

Modifier 53 – Discontinued Procedure

- Modifier 53 should be appended to a surgical code or medical diagnostic code when the procedure is discontinued because of extenuating circumstances.
- This modifier is used to report services or procedures when the service or procedure is discontinued after anesthesia is administered to the patient.
- This modifier should not be used to report an elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.
- Modifier 53 should not be used when a laparoscopic or endoscopic procedure is converted to an open procedure.
- Modifier 53 should not be appended to an E&M service.
- Documentation must support the use of this modifier. Documentation should include a statement indicating at what point the procedure was discontinued and/or the extenuating circumstances preventing the completion of the procedure.

Modifier 54 – Surgical Care Only (Optometrist and Ophthalmologist only)

- This modifier may be utilized by optometrists and ophthalmologists to allow for separate billing of surgical care only.
- Modifier 54 is reported when the ophthalmologist performed a surgical procedure only.
- Modifier 54 is appended only to the surgical code.
- Medical records are not required with the claim, but they must be available upon request.
- Documentation must support the use of this modifier.
- This modifier is only recognized by Blue Cross for cataract-related procedure codes.

Modifier 55 – Postoperative Management Only (Optometrist and Ophthalmologist only)

- This modifier may be utilized by optometrists to allow for separate billing of postoperative care only.
- Modifier 55 is reported when the optometrist performed the postoperative care only.
- Modifier 55 is appended only to the surgical code.
- Medical records are not required with the claim, but they must be available upon request.
- Documentation must support the use of this modifier.
- This modifier is only recognized by Blue Cross for cataract-related procedure codes.

Modifier 56 – Preoperative Management Only - (Optometrist and Ophthalmologist only)

- This modifier may be utilized by optometrists and ophthalmologists to allow for separate billing of preoperative care only.
- Modifier 56 is reported when the optometrist or ophthalmologist performed the preoperative care only.
- Modifier 56 is appended only to the surgical code.
- Medical records are not required with the claim, but they must be available upon request.
- Documentation must support the use of this modifier.
- This modifier is only recognized by Blue Cross for cataract-related procedure codes.

Modifier 57 – Decision for Surgery

- The purpose of this modifier is to report an E&M service that resulted in the initial decision to perform surgery by the same physician or physician with the same specialty and tax identification number on the day before or the day of a major surgical procedure (90-day global period).
- Modifier 57 is not used for minor procedures (0- or 10-day global period).
- Modifier 57 is appended to the appropriate level of E&M service that resulted in the initial decision to perform the surgical procedure.
- Modifier 57 should only be appended to an E&M service.
- Medical records are not required with claims, but they must be available upon request.
- Documentation must establish that the decision for surgery was made during a specific visit.
- This modifier is used in conjunction with the global surgery period.
- Effective January 1, 2013 this modifier is used in conjunction with NCCI Edits.

Modifier 58 – Staged or Related Procedure/Service by the Same Physician During the Postoperative Period

- This modifier is used to indicate that a procedure or service during a postoperative period was planned or anticipated (staged), more extensive than the original procedure, or for therapy following a surgical procedure.
- Modifier 58 is not to be used to report the treatment of a problem that requires a return to the operating room.
- Documentation is not required with claims, but it must be available upon request.
- Documentation should reflect the staged or related procedure.
- This modifier is used in conjunction with NCCI edits.

Modifier 59 – Distinct Procedural Service

The purpose of this modifier is to identify procedures or services, other than E&M services, that are not normally reported together but are appropriate under distinct circumstances. Listed below are some of the distinct circumstances where it may be appropriate to append modifier 59:

- Different session or patient encounter
- Different procedure or surgery
- Different site or organ system
- Separate incision or excision
- Separate lesion
- Separate injury or area of injury in extensive injuries

Other guidelines:

- Modifier 59 should not be appended to the E&M service.
- Modifier 59 should be appended to the secondary, additional or lesser procedure or service.
- Modifier 59 should not be used when another more descriptive modifier is available.
- Documentation should be specific to the distinct procedure or service and clearly identifiable in the medical record.
- For dates of service on or after January 21, 2009, through September 30, 2010, there are certain code pairs that will not be considered for separate payment when submitted with modifier 59. Refer to *ProviderAccess* – Fragmented Coding Exceptions – Modifier 59.
- For dates of service on or after October 1, 2010, modifier 59 exceptions have been removed.
- This modifier is used in conjunction with NCCI and Blue Cross edits.

Modifier 62 – Two Surgeons

- When two surgeons work together as primary surgeons performing distinct parts of a procedure, each surgeon should file his/her distinctive work by adding modifier 62 to the procedure code and any associated add-on codes for that procedure as long as both surgeons continue to work together as primary surgeons.
- Each surgeon should file the co-surgery once using the same procedure codes. If additional procedures are performed during the same surgical session, separate codes may be filed with modifier 62 appended.
- Documentation must support the medical necessity for two surgeons.

Modifier 63 – Procedure performed on infants less than 4 kg

Modifier 66 – Surgical Team

- Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specialty-trained personnel, various types of complex equipment) are carried out under the "surgical team" concept.
- Such circumstances may be identified by each participating physician filing the addition of modifier 66 to the basic procedure code used for filing the services.
- Documentation must support the need for team surgery.

Modifier 76 – Repeat Procedure or Service by the Same Physician

- This modifier is used to indicate that the same procedure or service was repeated subsequent to the original procedure or service.
- Documentation should indicate and support medical necessity.
- Documentation is not required with claims, but it must be available upon request.
- This modifier is used in conjunction with Blue Cross edits.

Modifier 78 – Unplanned Return to the Operating/Procedure Room by the Same Physician

- The modifier is used to indicate that an unplanned procedure was performed during the postoperative period of the initial procedure and requires the use of an operating or procedure room.
- Documentation should indicate and support medical necessity.
- Documentation is not required with claims, but it must be available upon request.
- This modifier is used in conjunction with NCCI edits.

Modifier 79 – Unrelated Procedure or Service by the Same Physician

- This modifier is used to indicate the performance of a procedure or service during the Post-operative period that is unrelated to the original procedure.
- Documentation should indicate and support medical necessity.
- Documentation is not required with claims, but it must be available upon request.
- This modifier is used in conjunction with NCCI edits.

Modifier 80 – Assistant Surgeon

Surgical assistant services may be identified by adding modifier 80 to all the surgical codes that apply.

Modifier 81 – Minimum Assistant Surgeon

Surgical assistant services may be identified by adding modifier 81 to all the surgical codes that apply.

Modifier 82 – Assistant Surgeon (when qualified resident surgeon is not available)

Use modifier 82 when a qualified resident surgeon is unavailable.

Modifier 90 – Reference (Outside) Laboratory

- When sending laboratory work to an outside laboratory to be analyzed, separate payment may be made for the venipuncture to draw the specimen.
- Use modifier 90 following the venipuncture procedure code.

Modifier 91 – Repeat Clinical Diagnostic Laboratory Test

- This modifier is used to indicate that the same laboratory test was performed more than once on the same day on the same patient.
- These modifiers are used in conjunction with NCCI edits.

Modifier 92 – Alternative laboratory platform testing

Modifier 99 – Multiple modifiers

Additional Modifiers

Modifier AA – (Anesthesia Only)

Anesthesia service performed personally by the anesthesiologist should have the modifier AA appended to the appropriate services.

Modifier AD

Medical supervision by a physician; more than four concurrent anesthesia procedures. (Three base units plus actual time unit allowed.)

Modifier AS – Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist Services for Assistant Surgery

- Surgical services must allow an assistant as surgery.
- This modifier should be appended to the appropriate surgical procedure code.

Modifier E1-E4 – Anatomical Modifier to Designate Right and Left Upper and Lower Eyelid

- These modifiers are used to indicate that the procedure or service was performed on the right or left upper and lower eyelids.
- These modifiers are used in conjunction with NCCI edits.

Modifier FA and F1-F9 – Anatomical Modifier to Designate Right and Left Hand and Each of the Digits

- These modifiers are used to indicate that procedures or services were performed on the right and left thumbs and fingers.
- These modifiers are used in conjunction with NCCI edits.

Modifier GZ – Item or Service Expected to be Denied as Not Reasonable and Necessary

- This modifier is appended to HCPCS code A4590 when filed with a procedure that involves casting.
- This modifier is used in conjunction with Blue Cross edits.

Modifier LC – Left Circumflex Coronary Artery

This modifier is used in conjunction with NCCI edits.

Modifier LD – Left Anterior Descending Coronary Artery

This modifier is used in conjunction with NCCI edits.

Modifier LM – Left Main Coronary Artery

Effective January 1, 2013 this modifier is used in conjunction with NCCI Edits.

Modifier LT and RT – Left Side of the Body (LT) and Right Side of the Body (RT)

- These modifiers are used to indicate when the procedure or service was performed on the right side or left side of the body.
- This modifier is used in conjunction with NCCI edits and Blue Cross edits.

Modifiers QK

Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.

Modifiers P1-P6 – Modifiers that Report Patient Condition (Anesthesia Only)

American Society of Anesthesiologists (ASA) physical status classification system for assessing a patient before surgery:

- P1 – A normal, healthy patient
- P2 – A patient with mild systemic disease
- P3 – A patient with severe systemic disease
- P4 – A patient with severe systemic disease that is a constant threat to life
- P5 – A moribund patient who is not expected to survive without the operation
- P6 – A declared brain-dead patient whose organs are being harvested.

Modifiers RC – Right Coronary Artery

This modifier is used in conjunction with NCCI edits.

Modifiers RI – Ramus Intermedius Coronary Artery

Effective January 1, 2013 this modifier is used in conjunction with NCCI Edits.

Modifier TA and T1-T9 – Anatomical Modifier to Describe Right and Left Foot Digits

- These modifiers are used to indicate that procedures or services were performed on the right and left toes.
- These modifiers are used in conjunction with NCCI edits and Blue Cross edits.

Specialized Modifiers

The following modifiers should be used for Erythropoiesis Stimulating Agents (ESAs) for patients with End-Stage Renal Disease – Refer to Erythropoiesis Stimulating Agent (ESAs) for additional information and guidelines.

- Modifier TR – Test results
- Modifier R1 – Hemoglobin
- Modifier R2 – Hematocrit
- Modifier EA – ESA, Anemia, Chemo-induced
- Modifier EB – ESA, anemia, Radio-induced
- Modifier EC – ESA, anemia, Non-chemo/radio
- Modifier EJ – Subsequent claims for a defined course of therapy