Modifier Guidelines

Origination Date: 01/23/2024
Last Review: 02/27/2024
Next Review: 02/2025

Description

According to the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS), a modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

Modifiers may be used to indicate that:

- A service or procedure has a professional or technical component.
- A bilateral procedure was performed.
- A service was distinct or separate.
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure has been increased or reduced.
- An add-on or additional service was performed.
- A service or procedure was provided more than once.
- A service or procedure was performed on a specific site.
- Only part of a service was performed.
- Unusual events occurred.

Certain modifiers are used for informational purposes only and do not affect reimbursement.

Policy

Oscar utilizes modifiers in determining reimbursement eligibility. When services are billed with inappropriate modifiers or the lack of an appropriate modifier according to our policy, it will not be eligible for reimbursement.

Reimbursement Guidelines

Modifiers Defined by CPT® Appendix A

- **Modifier 24- i**s used to report an evaluation and management service performed during a postoperative period by the same physician or same group practice for reasons unrelated to the original procedure. (See “Evaluation and Management Services”)
- **Modifier 25-**Significant, Separately Identifiable Evaluation and Management Service by the same Physician or other qualified healthcare professional on the same day of the procedure or other service **(**See “Evaluation and Management Services” reimbursement policy.)

- **Modifier 26**- designates the professional component of a procedure. When the physician's component is separately reportable, the service may be identified by appending modifier -26 to the procedure code. ****Note**- Oscar denies "Incident To" codes identified with a CMS PC/TC indicator 5 in the NPFS when reported in a facility place of service when billed by a physician. Modifiers -26 and TC cannot be used with these codes. Oscar does not reimburse codes identified by CMS as having no professional component (PC/TC Indicator of 3,4, or 9) when billed with a -26 modifier.
- **Modifier 47-** is used to report anesthesia by the attending or assistant surgeon. No additional benefits are allowed above the total allowed for the surgical procedure if the anesthesia services are not administered by, or under the supervision of, a doctor other than the attending surgeon or assistant surgeon.
- **Modifier 50-** designates a bilateral procedure performed at the same session. Use of the 50 modifier will not result in additional reimbursement when used with procedures which cannot be performed bilaterally or for which the base CPT code signifies a bilateral procedure. (See "Bilateral Procedures" Reimbursement Policy).
- **Modifier 51-**designates multiple procedures that are performed at the same session by the same provider, other than evaluation and management services, physical medicine and rehabilitation services, or provision of supplies. (Note: This modifier is not appropriate to append to evaluation and management services. This modifier is not to be appended to designated "add-on" codes.)(See "Multiple Procedures" Reimbursement Policy)
- **Modifier 52-**indicates that a service or procedure has been partially reduced or eliminated at the physician's discretion.
- **Modifier 53-**indicate a procedure was started but discontinued.
    - Modifier 53 is not appropriate for use with:
        - Facility billing
        - Evaluation and management (E/M) services
        - Elective cancellation of a service prior to anesthesia induction and/or surgical preparation in the operating suite.
        - Laboratory panel code
- **Modifier 57-** is appended when an evaluation and management service that results in the initial decision to perform surgery. It is intended to report that the decision to perform major surgery occurred on the day of or day prior to, a major (90-day global) surgical procedure. (See Evaluation and Management Services Policy.)
- **Modifier 59-** indicates when a procedure is distinct or independent from another non-evaluation and management service performed on the same day.

  ***Note**: The Centers for Medicare & Medicaid Services (CMS) has established four HCPCS modifiers to define subsets of the 59 modifier. These modifiers function in the same manner as modifier 59. Since the HCPCS modifiers are more detailed descriptions of modifier 59, it would be incorrect to include both on the same claim line according to CMS. Therefore, any code appended with 59 in addition to XE, XS, XO, or XU will not be eligible for reimbursement.
- **Modifier 62 and 66-** when appended indicates that services were performed by two surgeons or a surgical team, and will be reimbursed according to our "Co-Surgeons/Team Surgeons Reimbursement Policy".

- **Modifier 73-** when appended indicates that the procedure was discontinued prior to completion. This modifier is not applicable for professional provider billing.
- **Modifier 78 and 79-** unplanned return to surgery. In order for a procedure code billed with modifier 78 or 79 to be eligible for reimbursement, Oscar must have evidence that a procedure was billed on the same date of service or within the postoperative period as defined by the 0, 10, or 90 day postoperative period definition.
- **Modifiers 80, 81, 82-** are used to report Assistant Surgeon Services. See our "Assistant Surgeon Reimbursement Policy".
- **Modifier 90-**represents a reference (outside) laboratory and will only be eligible for reimbursement if billed by a provider with a specialty designation of Laboratory or Pathology.
- **Modifier 92-**is used for alternative laboratory platform testing. Only HIV testing will be eligible for reimbursement when billed. All other codes containing this modifier will not be eligible for reimbursement.
- **Modifier 95-**is used to designate when a service is a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified healthcare professional. See "Services Delivered via Telemedicine" Reimbursement Policy.
- **Modifier Use in Fracture Care-**When a fracture or dislocation care code is billed in the office setting and the same code has been billed by any provider in the past 10 days, it is assumed that the second billing of this code is duplicative, and it will be denied. When a fracture care code is billed in the office setting that is different from another fracture care code that was billed in the previous 2 weeks, it is assumed that the second code was inappropriately coded and that it also represents post-operative care for the earlier service. In this situation, the second code will be denied. An exception exists for procedures billed with an appropriate modifier which designates that the services are unrelated. The modifiers are listed below: ○ 55 (Post-operative management only)
    - 76 (Repeat procedure by same physician)
    - 77 (Repeat procedure by another physician)
    - 78 (Return to operating room for a related procedure during the postoperative period)
    - 79 (Unrelated procedure or service by same physician during the postoperative period)
    - Modifier 54 (surgical care only) is not appropriate to use with fracture care codes for closed treatment without manipulation in the emergency department.

Level II HCPCS/National Modifiers

Modifier AS- this modifier designates that services were provided by a physician assistant, nurse practitioner or nurse midwife for an assistant at surgery. Please refer to our "Assistant Surgeon" Reimbursement Policy.

Modifier AT- designates acute treatment and should be utilized when filing for CPT Codes 98940-98942.

Anatomic Modifiers Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims.

- **E1-E4 (Eyes)**
- **FA-F9 (fingers)**

- **TA-T9 (toes)**
- **Coronary Arteries (RC, LC, LD, RI, LM)**
- **RT/LT (right/left)**

Modifier GQ designates services performed via an asynchronous telecommunications system. Refer to policy titled "Services Delivered via Telemedicine".

Modifiers GP, GO, GN Oscar will require certain codes that are designated by CMS as "always therapy" to be filed with the appropriate modifier (GP, GO, or GN). This allows correct payment when they are performed under the physical therapy, occupational therapy, or speech-language pathology plan of care.

Modifier GT designates services performed via interactive audio and video telecommunication systems and will be reimbursed with codes specified in the reimbursement policy titled, "Services Delivered via Telemedicine."

Modifiers PA (surgical or other invasive procedure on wrong body part), **PB** (surgical or other invasive procedure on wrong patient), and **PC** (wrong surgery or other invasive procedure on patient) indicate Never Events and are not considered reimbursable services.

Modifier PI and PS- Oscar requires PET scans to be billed with a PI or a PS modifier to be considered reimbursable. See "Radiology" Reimbursement Policy.

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

Modifier SL- State supplied vaccine. Vaccines and toxoids provided at no cost by the state are not eligible for reimbursement.

Modifier TC designates the technical component of a service. When the technical component is separately reportable, the service may be identified by appending modifier TC to the procedure code.

*****Note-** Oscar does not reimburse technical component services billed separately from the facility claim when performed in a facility place of service.

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

Anesthesia Modifiers Physicians must report appropriate anesthesia modifiers with general anesthesia services to denote whether the service was personally performed, medically directed, medically supervised, or represented by monitored anesthesia care. Also, services rendered by CRNAs must report the appropriate anesthesia modifier to indicate whether the service was performed with or without medical direction by a physician. Appropriate **modifiers for anesthesia services are: AA, AD, GC, QK, QX, QY, and QZ**. General anesthesia services (CPT 00100-01969)* will be denied if billed without an appropriate modifier. Anesthesia modifiers should only be appended to anesthesia services. Additional service modifiers may be appropriate to use for anesthesia services, however when inappropriate service modifiers are appended to an anesthesia code, that service will not be eligible for reimbursement. (See also reimbursement policy titled, "Anesthesia")

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

Rationale

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

Coding

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

Related Policies

Anesthesia
Assistant Surgeon
Bilateral Procedures
Co-Surgeons/Team Surgeons
Evaluation and Management Services
Multiple Procedures
Radiology
Services Delivered via Telemedicine

References

1. Centers for Medicare & Medicaid Services, CMS Manual System, and Medicare Claims Processing Manual 100-04
2. American Medical Association, Current Procedural Terminology (CPT®)
3. Centers for Disease Control and Prevention, International Classification of Diseases, 10th Revision
4. Healthcare Common Procedure Coding System

Publication History

Date Action	Description
2/27/2024	New Policy Development. Reimbursement Governance Committee Approved.