MODIFIERS

Policy # 17

Implementation Date: 1/1/02
Revision Dates: 6/30/05, 1/8/10, 4/26/10, 10/1/10, 8/21/14

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for SelectHealth Commercial, SelectHealth Advantage (Medicare), and SelectHealth Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description

Modifiers are used in conjunction with CPT and HCPCS codes to report additional information. SelectHealth accepts all HIPAA compliant modifiers for adjudication if they are valid with the CPT codes billed but may not recognize them for payment.

Commercial Plan Policy

The following is a list of modifiers that **may** affect claims adjudication. If it affects pricing, then the fee schedule for the five-digit code will be changed based on the modifier. If it affects editing, then specific edits that may apply for a five-digit code may not apply if one of these modifiers is appended. Some modifiers flag claims for manual review in order to adjudicate appropriate benefits.

Modifier	Affects Editing			Affects Pricing			Additional info or Review
	Commercial	Medicare	Medicaid	Commercial	Medicare	Medicaid	
22 - Increased Procedural Services	NO	NO	NO	MAYBE	MAYBE	MAYBE	Manual review is required to determine if additional payment will be made based on documentation. Documentation is required.
23 - Unusual Anesthesia:	NO	NO	NO	NO	NO	NO	No manual review necessary

24 - Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period:	YES	YES	YES	NO	NO	NO	If billed on and Evaluation and Management codes during global period of an unrelated procedure modifier –24 may allow payment for E/M service.
25 - Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service:	YES	YES	YES	NO	NO	NO	When an E/M service is performed on the same day of a procedure and is above and beyond what is normally included in the procedure, and represents a separately identifiable service modifier -25 may allow payment for the E/M service.
26 - Professional Component	YES	YES	YES	YES	YES	YES	No manual review necessary
47 - Anesthesia By Surgeon	NO	NO	NO	YES	YES	YES	Manual review required for pricing. Modifier –47 should be billed on code for the procedure.

50 - Bilateral Procedure	NO	NO	NO	NO	NO	NO	In order to receive appropriate reimbursement for bilateral procedures, SelectHealth would recommend billing the procedure once with the LT and then again with the RT instead of using the 50 modifier.
51 - Multiple Procedures	NO	NO	NO	NO	NO	NO	No manual review necessary. System will automatically price multiple surgeries.
52 - Reduced Services	NO	NO	NO	YES	YES	YES	An automatic 25% reduction will apply. **This is the same for all lines of business.**
53 - Discontinued Procedure	NO	NO	NO	YES	YES	YES	An automatic 25% reduction will apply. **This is the same for all lines of business.**
54 - Surgical Care Only	YES	YES	YES	YES	YES	YES	Payment will be based off of Medicare's percentage of the service that is for surgical and preoperative care.
55 - Postoperative Management Only	YES	YES	YES	YES	YES	YES	Payment will be based off of Medicare's percentage of the service that is for postoperative management only.

56 - Preoperative Management Only	YES	YES	YES	YES	YES	YES	Payment will be based off of Medicare's percentage of the service that is for preoperative management only.
57 - Decision for Surgery	YES	YES	YES	NO	NO	NO	When an E/M service is performed on the same day of a procedure and the decision for surgery is made through the evaluation and management service modifier – 57 may allow payment for the E/M service.
58 - Staged or Related Procedure or Service by the Same Physician During the Postoperative Period	NO	YES	YES	NO	NO	NO	No manual review necessary
59 - Distinct Procedural Service	NO	YES	NO	NO	NO	NO	Modifier -59 may or may not override edits initially. The 59 modifier will be reviewed on appeal if denied and it should only be used on codes that are normally edited and denied if they meet the criteria outlined in 59-modifier policy.

62 - Two Surgeons	YES	YES	YES	YES	YES	YES	Pays 62.5% of the Fee schedule to each physician. Each physician should have their own operative report that reports the portion of the procedure they performed. **This is the same for all lines of business.**
63 - Procedure Performed on Infants less than 4 kg	NO	NO	NO	MAYBE	MAYBE	MAYBE	Manual review is required to determine if additional payment will be made based on documentation. Documentation is required.
66 - Surgical Team	YES	YES	YES	YES	YES	YES	Pays 60% of the Fee schedule to each physician. Each physician should have their own operative report that reports the portion of the procedure they performed. **This is the same for all lines of business.**
73 – Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia	YES	YES	YES	NO	NO	NO	Manual review is required and may decrease allowed amount based on documentation.

74 – Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia	NO	NO	NO	NO	NO	NO	Manual review is required and may decrease allowed amount based on documentation.
76 Repeat Procedure by Same Physician	YES	YES	YES	NO	NO	NO	Manual review may be required to allow additional charges and verify charges are not duplicates.
77 Repeat Procedure by Another Physician	YES	YES	YES	NO	NO	NO	Manual review may be required to allow additional charges and verify charges are not duplicates.
78 Return to the Operating Room for a Related Procedure During the Postoperative Period	YES	YES	YES	YES	YES	YES	No manual review necessary.
79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period	YES	YES	YES	NO	NO	NO	No manual review necessary.

80/81/82/AS Assistant Surgeon	YES	YES	YES	YES	YES	YES	Assistant surgeon modifiers should not be billed by both the primary surgeon and the assistant surgeon. Credentialed PAs or NPs may use the AS modifier for payment when assisting in surgery. For Commercial and Medicaid, **80/82** pays 20% of fee schedule. For Medicare, 80/82 pays 16% of fee schedule. **81** pays 16% of fee schedule for all lines of business. Commercial and Medicaid pay 12% of fee schedule for the **AS** modifier. Medicare pays13.6% of the fee schedule for the **AS** modifier.
90 Reference (Outside) Laboratory	NO	NO	NO	NO	NO	NO	No manual review necessary.
91 Repeat Clinical Diagnostic Laboratory Test	NO	NO	NO	NO	NO	NO	Manual review may be required for duplicate charges.
99 Multiple Modifiers	NO	NO	NO	NO	NO	NO	Requires manual review to see what modifiers this replaces.
TC Technical Component	YES	YES	YES	YES	YES	YES	No manual review necessary.
P1: A normal healthy patient	NO	NO	NO	NO	NO	NO	No manual review necessary.
P2: A patient with mild systemic disease	NO	NO	NO	NO	NO	YES	No manual review necessary.

P3: A patient with severe systemic disease	NO	NO	NO	YES	NO	YES	No manual review necessary.
P4: A patient with severe systemic disease that is a constant threat to life	NO	NO	NO	YES	NO	YES	No manual review necessary.
P5: A moribund patient who is not expected to survive without the operation	NO	NO	NO	YES	NO	YES	No manual review necessary.
P6: A declared brain-dead patient whose organs are being removed for donor purposes	NO	NO	NO	NO	NO	NO	No manual review necessary.
L1: Provider attestation that the hospital laboratory test(s) is not packaged under the hospital OPPS	YES	YES	YES	NO	NO	NO	No manual review necessary.
E1: Upper let eyelid	YES	YES	YES	NO	NO	NO	No manual review necessary.
E2: Lower left, eyelid	YES	YES	YES	NO	NO	NO	No manual review necessary.
E3: Upper right eyelid	YES	YES	YES	NO	NO	NO	No manual review necessary.
E4: Lower right eyelid	YES	YES	YES	NO	NO	NO	No manual review necessary.
F1: Left hand, second digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
F2: Left hand, third digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
F3: Left hand, fourth digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
F4: Left hand, fifth digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
F5: Right hand, thumb	YES	YES	YES	NO	NO	NO	No manual review necessary.
F6: Right hand, second digit	YES	YES	YES	NO	NO	NO	No manual review necessary.

F7: Right hand, third digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
F8: Right hand, fourth digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
F9: Right hand, fifth digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
FA: Left hand, thumb	YES	YES	YES	NO	NO	NO	No manual review necessary.
LT: (Left side)	YES	YES	YES	NO	NO	NO	No manual review necessary.
RT (Right side)	YES	YES	YES	NO	NO	NO	No manual review necessary.
T1: Left foot, second digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
T2: Left foot, third digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
T3: Left foot, fourth digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
T4: Left foot, fifth digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
T5: Right foot, great toe	YES	YES	YES	NO	NO	NO	No manual review necessary.
T6: Right foot, second digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
T7: Right foot, third digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
T8: Right foot, fourth digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
T9: Right foot, fifth digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
TA: Left foot, great toe	YES	YES	YES	NO	NO	NO	No manual review necessary.
NU New equipment	NO	NO	NO	YES	YES	YES	No manual review necessary.
RR Rental	NO	NO	NO	YES	YES	YES	No manual review necessary.
UE Used durable medical equipment	NO	NO	NO	YES	YES	YES	No manual review necessary.

MS Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty	NO	NO	NO	YES	YES	YES	No manual review necessary.

Modifiers not recognized for payment	Affects Coverage			Additional info or Review
	Commercial	Medicare	Medicaid	
EY No physician or other licensed health care provider order for this item or service	YES	YES	YES	No manual review necessary.
GF Non-physician 9e.g. nurse practitioner (NP), certified registered nurse anesthetist (CRNA), certified registered nurse (CRN), clinical nurse specialist (CNS), physician assistant (PA) services in a critical access hospital	YES	NO	YES	No manual review necessary.

GL Medically unnecessary upgrade provided instead of standard item, no charge, no advance beneficiary notice (ABN)	YES	MAYBE	YES	No manual review necessary.
HD Pregnant/parenting women's program	YES	YES	YES	No manual review necessary.
HJ Employee assistance program	YES	YES	YES	No manual review necessary.
HM Less than bachelor degree level	YES	YES	YES	No manual review necessary.
Q5 Service furnished by a substitute physician under a reciprocal billing arrangement	YES	NO	YES	No manual review necessary.
Q6 Service furnished by a locum tenens physician	YES	NO	YES	No manual review necessary.
QV Item or service provided as routine care in a Medicare qualifying clinical trial	YES	YES	YES	No manual review necessary.
SE State and/or federally funded programs/services	YES	YES	NO	No manual review necessary.
SU Procedure preformed in physician's office (to denote use of facility and equipment)	YES	YES	YES	No manual review necessary.
SL Modifier	YES	YES	NO	No manual review necessary.

TM Individualized education program (IEP)	YES	YES	YES		No manual review necessary.

SelectHealth Advantage (Medicare/CMS)

See table above

SelectHealth Community Care (Medicaid)

See table above

Applicable Codes

Modifiers	Descriptions
See above	See above

Sources

1. *Current Procedural Terminology (CPT®),* (2014) – American Medical Association
2. ICD-9-CM Coding Guidelines. (2013, January 1). Retrieved July 8, 2014, from https://www.encoderpro.com/epro/physicianDoc/pdf/i9v1/i9_guidelines.pdf
3. Utah Department of Health. (2014, October 1). PHYSICIAN SERVICES. Retrieved November 3, 2014, from https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Physician%20And%20Anesthesiology/SECTION%202%20-%20Physician%20Services/Physician10-14.pdf