Commercial Reimbursement Policy

Subject: **Modifier Rules - Professional**	
Policy Number: **C-08010**	Policy Section: **Coding**
Last Approval Date: **04/01/2024**	Effective Date: **07/01/2024**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem Blue Cross (Anthem) member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, Anthem will publish the most current policy to the website.

Policy

The Health Plan accepts all HIPAA compliant American Medical Association (AMA) CPT and HCPCS modifiers for claims processing. The Health Plan treats some modifiers as "informational only"; some modifiers are important to the adjudication of the claim; and some modifiers may affect the percentage of the allowance. Providers must follow proper coding guidelines as set by CPT or The Centers for Medicare & Medicaid Services (CMS) when reporting modifiers.

The use of certain modifiers require the provider to submit supporting documentation along with the claim. Refer to the specific modifier policies for guidance on documentation submission. The Health Plan reserves the right to review adherence to correct coding for high-volume modifiers.

When multiple procedures are performed on a date of service and one line includes a site specific modifier, the Health Plan requires that all subsequent procedure codes also include a site specific modifier. When only one line is reported with a site specific modifier and subsequent lines are reported without a site specific modifier, the Health Plan will consider the additional procedure(s) to be same site as the modified procedure, which may result in the subsequent procedure(s) being denied.

The Health Plan also uses modifier to procedure code validation to verify a modifier is inappropriately used with a procedure code. When an invalid modifier to procedure code combination is detected, the line item will be denied with a request that the correct code and modifier combination be resubmitted.

When multiple modifiers that apply a percentage amount to the allowance are reported with a procedure, the system will multiply the percentage amounts together to determine a new percentage amount. When the new percentage amount contains a decimal place, the system will round the new percentage amount up to the next whole percentage and apply this whole percentage amount to the allowance for the procedure the modifier was reported with.

Related Coding

Description	Comments
Modifiers Impacting Adjudication	Modifiers Impacting Adjudication
Informational Modifiers	Informational Modifiers

Policy History

04/01/2024	Review approved 04/01/2024 and effective 07/01/2024: updated Related Coding section Modifiers Impacting Adjudication • added modifier FT is required for unrelated evaluation and management (E/M) visits during a postoperative period for critical care codes 99291, 99292, 99468, 99469, 99471, 99472, 99475, and 99476 • added modifier 93 and FQ Informational Modifiers • added modifier FS
10/01/2021	Review approved 10/01/2021 and effective 01/01/2022: Modifier 90 will not allow reimbursement when reported in a Place of

	Service 11 (Office); Modifier FB will not be allowed when appended to CPT/HCPCS.
11/23/2020	Review approved 11/23/2020 and effective 04/01/2021; updated policy language; added modifiers K0, K1, K2, K3 and K4; updated modifiers definitions and comments; updated Related Coding Section, and Related Policies and Materials
06/01/2019	Policy template updated; description section was removed
03/28/2019	Review adherence to correct coding language added
10/26/2018	Review approved; Modifier definition updated with current CPT modifier definitions
08/01/2017	Review approved and effective; Updated modifier 92 (Alternative Laboratory Platform Testing) that only HIV testing 86701-86703, and 87389 are allowed to be reported with modifier 92; all other lab codes will not be eligible for reimbursement based on invalid modifier; correct coding based on CPT
06/06/2017	Review approved and effective 06/06/2017; Updated policy language, updated modifiers Q5 and Q6
02/07/2017	Review approved and effective 02/07/2017; Update modifier 91 will not override the denial of component laboratory codes for the laboratory panel bundling edit, Update description of modifiers QX and QY
10/04/2016	Review approved 10/04/2016 and effective 01/01/2017; Added modifier 95 to policy for 01/01/2017; identified telehealth services when reported with CPT codes in 2017 CPT Appendix P. Added note that modifier 55 is not to be reported with 0 global days procedures.
06/07/2016	Review approved and effective 06/07/2016; Updated policy language to include modifiers BP, BR, EX, Added modifiers BP, BR, EX, Updated modifier NR
04/05/2016	Review approved and effective 04/05/2016; Updated modifiers 91, KI, KR, LL, NR, RR
03/01/2016	Review approved and effective 03/01/2016; Updated modifiers 50, GQ, GT, KC, LT, NR, NU, RA, RB, RT, UE
01/05/2016	Review approved 01/05/2016 and effective 01/01/2016; Added modifier CT effect 01/01/2016 Computed tomography services furnished using equipment that does not meet each of the attributes of the national electrical manufacturers association (nema) xr-29-2013 standard, Updated modifiers G8, G9, P3-P5, QK, QS, QX, QY
12/01/2015	Review approved and effective 12/01/2015; Updated policy language to include G8, G9, and QS. Moved modifiers G8, G9, QS (Monitored anesthesia care) from the informational only to the first part of the policy that the use of these modifiers with general anesthesia will cause the anesthesia service to deny; the modifiers are informational only and do not apply any pay

	percent; Added language to modifiers LT or RT that when they are reported with a procedure that includes “bilateral” or “unilateral or bilateral” in the description, the procedure will not be eligible for reimbursement
10/06/2015	Review approved and effective 10/06/2015; Added modifiers KI, KR, Updated modifiers LL, NR, RR, Note added to KI, KR, LL, NR, and RR that orthotics and prosthetics classified as purchase only items will not be eligible for reimbursement when reported with rental modifiers
04/07/2015	Review approved and effective 04/07/2015; Updated modifier SA and 25 Updated language for modifier SA to add the word “surgical” to indicate that surgical procedures are not eligible for reimbursement when reported with modifier “SA”
02/03/2015	Review approved and effective date 02/03/2015; Updated modifiers RA and RB to include that replacement (RA) or repair or replacement part (RB) of member owned equipment may be eligible for reimbursement
01/20/2015	Review approved and effective date 01/20/2015; Added modifier SA to the policy--Nurse Practitioner rendering service in collaboration with a physician; services and procedures reported with this modifier will not be eligible for reimbursement
01/06/2015	Review approved and effective 01/06/2015; Adding modifiers XE, XP, XS, and XU to the policy indicating that services billed with one of these X modifiers will be processed in accordance with the Modifiers 59 and X{EPSU} policy
08/05/2014	Review approved and effective 08/05/2014; Updated Modifier 25 and 57
06/03/2014	Review approved and effective 06/03/2014; Updated language for modifier 25—problem-oriented E/M reported with modifier 25 and eligible with preventive care E/M—the allowance for the problem-oriented E/M will be reduced by 50%; comment for modifier 63 was updated to say Procedures reported with modifier 63 are eligible for additional reimbursement except for: Those services noted in the modifier 63 description that should not be appended with modifier 63 (for instance, E/M, pathology…) those services otherwise designated by CPT as not eligible to be appended with modifier 63, CPT codes listed in Appendix F of the CPT manual
03/04/2014	Review approved and effective 03/04/2014; Add modifier SG
02/05/2013	Review approved 02/05/2013 to add Frequency policy to the reference section
12/03/2013	Review approved and effective 12/03/2013; Description section updated, Policy section was updated to include KC, LL, NR, NU, RA, RB, RR, RU, Modifier updates for 24, 25, 50, 54, 55, 56, 57, 59, CC, Updates consist of: Add KC, LL, NR, NU, RA, RB, RR, and UE to the list of modifiers the Health Plan validates are

	being properly reported with procedure codes, Minor updates to language under modifiers 24 & 25 to read "…may override …" rather than "…will override…" Under modifier 50—updating name of multiple surgery policy to Multiple and Bilateral Surgery Processing and adding reference for the Multiple Diagnostic Imaging policy. Updated comments section for modifier 50, update to the language in the last line of the bracketed language for diagnostic services to read: Therefore, bilateral procedures for this type of service are to be reported on two lines with the LT and RT site-specific modifiers. Modifiers 54, 55, and 56 Including language which states that the modifiers are used when one provider performs the surgical procedure and another renders the care only (preop or postop)
03/05/2013	Review approved and effective 03/05/2013; updated Disclaimer, Description section and modifiers in Policy section, Modifiers added LM, RI
02/05/2013	Review approved and effective 02/05/2013; Updated Modifier 91 When modifier 91 is appended to a reported laboratory procedure code, our claims editing system will override a frequency edit and allow separate reimbursement for the repeat clinical diagnostic laboratory test except as described in our Frequency Editing reimbursement policy related to drug screen testing"
06/05/2012	Review approved and effective 06/05/2012; Updated Modifiers KC, NR, NU, RA, RB UE
05/01/2012	Review approved and effective 05/01/2012; Updated modifiers 25, 80, 81, 82, AS, SU Added Modifiers KC, NR, NU, RA, RB, NR, UE Language updates to modifiers 25: Removed [E/M codes appended with modifier 25 and reported with specific allergy and dermatologic procedures are processed and reimbursed at 50% of the [maximum allowance.] Updated Modifiers 80, 81, & 82 Added bullet to each: Modifier 8X should not be used to report assistant surgeon services rendered by non-physician providers. Modifier AS is to be used for reporting assistant-at-surgery services by non-physician providers. Added KC, NR, NU, RA, RB, and UE Added Modifier SU Procedures reported with modifier SU will not be eligible for separate reimbursement. Use of an office facility and equipment are included in the practice expense of the Relative Value Unit (RVU) for a rendered service or procedure.
04/03/2012	Review approved and effective 04/03/2012; Updated modifier SU,
03/06/2012	Review approved and effective 03/06/2012; Added modifier SU
11/01/2011	Review approved and effective 11/01/2011; Updated modifiers 22, 24, 25, 50, 59, 62, 66, 90, PA, PB, PC. Added Modifiers 32 & 58

06/07/2011	Review approved and effective 06/07/2011; Added Modifier QK, QX, QY
03/01/2011	Review approved and effective 03/01/2011; Policy language updated. Modifier 91 --The language in the first bullet in the Comments column was updated to match the description. “Laboratory” was added and diagnostic test replaced “procedure/service.” The 2nd bullet about “may be reviewed” was removed. Comment sections updated, Modifiers 33, 99, AD and PT were added to the 2nd coding
07/06/2010	Review approved and effective 07/06/2010; changes to modifiers 91, 99, AD, SL, 51, QL, QS, QZ. Added modifiers MS & SL. The modifier validation list in the policy section was consolidated. MS was also added there and to the coding table as a pricing modifier. Mod 91 was moved from Sec 2-informational to Section 1 and indicates that it is recognized that the 2nd billing is not a duplicate billing.
02/04/2010	Review approved and effective 02/04/2010; Updated Modifier 25 revisions In the description section: the policy reference for Claim Editing Overview and Global Surg was removed; just the E/M Mod 25 policy reference remains. In the Comments Section: the reference that Mod 25 overrides ME edit for 2 E/Ms was removed since it currently does override. The statement that mod 25 does override problem E/M with preventive was added. Mod 76-77 revisions. Wording was fixed to indicate current processing. Mod 21 was deleted; Added modifier AI.
10/26/2009	Review approved and effective 10/26/2009; Updated Policy language Description: “two digit alpha numeric character” changed to “two character alpha numeric indicator Policy Section: 1st paragraph from “but not necessarily for compensation” to “not always to determine compensation”; and the description of CMS was added. Added modifier PA, PB, PC, reference section updated, Header and Footer updated and Policy History added
10/06/2009	Review approved and effective 10/06/2009; Added Modifier 52 & 53
05/04/2009	Review approved and effective 05/04/2009; Added Mod 90 to be informational
12/02/2008	Review approved and effective 12/02/2008; Informational modifiers have been separated from modifiers that impact payment.
11/04/2008	Review approved and effective 11/04/2008; Added modifiers GC, GE, GR, verbiage for Mod 22 was updated to match CPT
09/18/2008	Review approved and effective 09/18/2008; added modifiers 73 and 74
09/18/2008	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- AMA CPT 2022 Professional Edition
- AMA HCPCS 2022 Expert Edition
- CMS
- Optum EncoderPro 2022

Definitions

Modifier	A two-character alpha/numeric indicator that is appended to a *Current Procedural Terminology* (CPT®') or Healthcare Common Procedure Coding System (HCPCS Level II) code. It is used as a means of reporting a specific circumstance that further defines or alters the code; but it does not change the definition of the procedure performed or item procured.

Related Policies and Materials

Ambulance Transportation - Professional
Assistant at Surgery (Modifiers 80, 81, 82, AS) – Professional
Bundled Services and Supplies – Professional
Code and Clinical Editing – Professional
Claims Requiring Additional Documentation – Professional and Facility
Distinct Procedural Service, Modifiers 59 and XE, XP, XS, & XU – Professional
Documentation and Reporting Guidelines for Evaluation and Management Services - Professional
Durable Medical Equipment – Rent to Purchase – Professional
Durable Medical Equipment – Modifiers – Professional
Modifiers 25 and 57 – Professional
Frequency Editing – Professional
Global Surgical Package – Professional
Injectable Substances with Related Injectable Services – Professional
Laboratory and Venipuncture Services – Professional and Facility
Modifier 22 – Professional
Modifier 26 and TC: Professional and Technical Component - Professional
Modifier 62: Co-Surgeon Services
Modifier 66: Surgical Team
Multiple and Bilateral Surgery Processing – Professional
Multiple Diagnostic Imaging Procedures – Professional
Place of Service – Professional
Professional Anesthesia Services – Professional
Virtual Visits – Professional

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in

effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.