



## Corporate Medical Policy

### Modifier Guidelines

**File Name:** modifier\_guidelines  
**Policy Number:** ADM9080  
**Origination:** 01/2000  
**Last Review:** 07/2009  
**Next Review:** 07/2010

#### Description of Procedure or Service

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A modifier provides the means by which the reporting physician can 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. The use of modifiers eliminates the need for separate procedure listings that may describe the modifying circumstances. Modifiers may be used to indicate to the recipient of a report that:

- A service or procedure has both a professional and technical component.
- 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.
- Only part of a service was performed.
- An add-on or additional service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.
- A service or procedure was performed on a specific site.

#### Policy Statement

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**CPT modifiers that may affect claims payment are; -22, -24, -25, -26, -47, -50, -51, -54, -55, -56, -57, -59, -62, -66, -80, -81, and -82. HCPCS modifiers that may affect claims payment are; -AS, -TC, E1-E4, FA-F9, GQ, GT, TA-T9, -RT, -LT, -LC, -LD, -MS, -PA, -PB, -PC, -RC, and -RP.**

#### Benefits Application

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Please refer to Certificate for availability of benefits. This policy relates only to the services or supplies described herein. Benefits may vary according to benefit design, therefore certificate language should be reviewed before applying the terms of the policy.

#### When a Modifier may be covered

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- Modifier - 24 can be submitted with evaluation and management services. It is used to report an unre-

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lated evaluation and management service by the same physician during a postoperative period.

- Modifier - 25 can be submitted with evaluation and management services for office, ambulatory, or outpatient department-services. It is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a service.
- Modifier -26 designates the professional component of a procedure. The acceptance of modifier -26 with a procedure is based on HCFA RBRVS. When processing modifier -26, the professional RVU is allowed.
- Modifier -50 designates the performance of a bilateral procedure. The acceptance of modifier -50 with a procedure is based on clinical consultant review.
- Modifier -51 designates the performance of multiple procedures, other than evaluation and management services, indicating an additional service or procedure has been performed.
- Modifier -54 designates Surgical care only, for use when one physician performs a surgical procedure and another provides preoperative and/or postoperative management.
- Modifier -55 designates Postoperative management only, for use when one physician performed the postoperative management and another physician performed the surgical procedure.
- Modifier -56 designates Preoperative management only, for use when one physician performed the preoperative care and evaluation and another physician performed the surgical procedure.
- Modifier 57 - is an evaluation and management service that results in the initial decision to perform surgery.
- Modifier -59 designates a distinct procedural service, other than evaluation and management services.
- Modifiers -62 and -66 designate services performed by two surgeons or a surgical team, and will be reviewed on an individual consideration basis.
- Modifiers -80, -81, and -82 designate assistant surgeon services. Blue Cross and Blue Shield of North Carolina uses ClaimCheck® as its primary source for determining those procedures available for assistant surgeon benefits. The assistant surgeon classifications assume that the assistant surgeon is board-certified or otherwise highly qualified as a skilled surgeon. Automatic edits are performed on assistant surgeon claims to determine if any procedures have been inappropriately billed by a surgical assistant. If guidelines are not met, the claim will suspend.
- Modifier -AS designates that services were provided by a physician assistant, nurse practitioner or nurse midwife for an assistant at surgery. Blue Cross and Blue Shield of North Carolina uses ClaimCheck® as its primary source for determining those procedures available for assistant surgeon billing by physician assistants, nurse practitioner or nurse midwife. Automatic edits are performed to determine if any procedures have been inappropriately billed by the physician assistant, nurse practitioner or nurse midwife.
- HCPCS site-specific modifiers E1-E4 (eyelids), FA-F9 (fingers), TA-T9 (toes), -RT (right), -LT (left), and -LC, -LD, and -RC (coronary vessels), are helpful in determining claims payment when multiple surgical procedures are performed on different anatomical sites during the same operative session.
- Modifier GT - Via interactive audio and video telecommunication systems will be allowed with code 99201 - 99205, 99212 - 99215(Office or Other Outpatient Services) and 99241 - 99245 (Office or Other Outpatient Consultations).
- Modifier - MS a six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty.
- Modifier - RP Replacement and repair may be used to indicate replacement of DME, orthotic and prosthetic devices which have been used for sometime.
- Modifier -TC designates technical component services were provided and will be allowed at a reduced rate in comparison to the allowance for the full service.

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### When a Modifier may not be covered

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- Modifier -22 will not affect claims processing adjudication. In general, BCBSNC does not allow a severity adjustment to fee allowances. Payment for new technologies is based on the outcome of the treatment rather than the "technology" involved in the procedure.
- The modifier -25 will not be recognized with a minimal office visit for an established patient (99211) performed on the same date as a preventative medicine visit (99391 - 99397).
- 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 the performance of a bilateral procedure. Clinical consultant review may determine these services will not be allowed.
- Modifier -51 will not be accepted with evaluation and management services. If used, the claim for services will not be allowed. Response will be; "Invalid Modifier/Procedure Combination."
- Modifiers -80, -81, and -82 for assistant surgeon services will not be allowed if they do not meet BCBSNC guidelines for appropriateness, Blue Cross and Blue Shield of North Carolina uses ClaimCheck® as its primary source for determining those procedures available for assistant surgeon benefits. Claims will be denied if the assistant surgeon is not board-certified or otherwise highly qualified as a skilled surgeon. Claims with procedures determined not to require an assistant surgeon will be denied as; "Does Not Require An Assistant Surgeon."
- Modifier GQ - Via asynchronous telecommunications system will not be allowed specifically with code 99201 - 99215(Office or Other Outpatient Services) and 99241 - 99245(Office or Other Outpatient Consultations).
- Modifier GT - will not be recognized with a minimal office visit for an established patient (99211).
- Modifier PA - Surgical or other invasive procedure on wrong body part. Refer to Corporate Medical Policy titled "Nonpayment for Serious Adverse Events"
- Modifier PB - Surgical or other invasive procedure on wrong patient. Refer to Corporate Medical Policy titled "Nonpayment for Serious Adverse Events"
- Modifier PC - Wrong surgery or other invasive procedure on patient. Refer to Corporate Medical Policy titled "Nonpayment for Serious Adverse Events"

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

#### **BCBSNC claims systems process only one modifier per CPT code.**

BCBSNC does not reimburse for evaluation and management and consultation services provided via telephone, Internet, or other communication network or devices that do not involve direct, in-person patient contact.

### Billing/Coding/Physician Documentation Information

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This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at [www.bcbsnc.com](http://www.bcbsnc.com). They are listed in the Category Search on the Medical Policy search page.

*Applicable codes:*

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*Modifiers must be appropriate to the combined procedure code.*

### Scientific Background and Reference Sources

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Medical Policy Advisory Group - 10/2003

Medical Policy Advisory Group - 03/10/2005

### Policy Implementation/Update Information

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- 1/00 Implementation
- 1/00 Revised to correct billing guideline for modifier -50.
- 3/00 Removed Blue Edge reference.
- 8/00 Clarification that -59 modifier will affect claims processing for Blue Care, Blue Choice, Blue Options, and Classic Blue in the 'When it is covered' and 'When it is not covered' sections.
- 01/02 Updated information pertaining to the place of service for a -25 modifier. Section added to indicate when a -25 modifier is not covered. Added information pertaining to the -57 modifier in both the covered and non-covered sections.
- 05/03 Added modifier - MS and -RP in the 'When it is covered' section.
- 10/03 Medical Policy Advisory Group review - 10/2003.
- 02/04 This policy applies to Blue Care, Blue Choice, Blue Options, and Classic Blue products only. Clarified this point in the policy. Statement removed from modifier -59 explanation.
- 4/07/05 Medical Policy Advisory Group reviewed policy on 03/10/2005. Medpoint and PCP removed from this policy. Corrected typos.
- 3/16/06 Renamed sections "When it is covered" and "When it is not covered" to read "When a modifier may be covered" and "When a modified may not be covered." Added the policy number to Key Words section. Added the following statement "Blue Cross and Blue Shield of North Carolina uses the American College of Surgeons as its primary source for determining those procedures available for assistant surgeon benefits to Modifier -80, -81, -82 and AS. Modifier -21 removed from policy. Statement that applied to PPO/CMM was removed from modifier -59.
- 5/8/06 Added statement to the section "When a modifier may not be covered" to read: Modifier -22 will not affect claims processing adjudication. In general, BCBSNC does not allow a severity adjustment to fee allowances. Payment for new technologies is based on the outcome of the treatment rather than the "technology" involved in the procedure. Added policy number to Key Words section. Medical Policy Advisory Group review 3/24/06 including revisions noted above. No additional changes required to policy criteria.
- 10/16/06 In the section "When a Modifier may be covered" revised procedure(s) to service(s) pertaining to Modifier -25. Statement added "The - 25 modifier will not be recognized with a minimal office visit for an established patient (99211) performed on the same date as a preventative medicine visit (99391 - 99397)." Removed the statement "Modifier - 25 is not recognized for an separate E&M service performed on the same date as a preventive medicine visit." in the section "When a Modifier may not be covered."
- 9/10/07 Modifier GT - Via interactive audio and video telecommunication systems will be allowed with code 99201 - 99205, 99212 - 99215(Office or Other Outpatient Services) and 99241 - 99245 (Office or Other Outpatient Consultations) added to "When a Modifier may be covered". Modifier GQ - Via asynchronous telecommunications system will not be allowed specifically with code

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99201 - 99215(Office or Other Outpatient Services) and 99241 - 99245(Office or Other Outpatient Consultations) and Modifier GT - will not be recognized with a minimal office visit for an established patient (99211) added to “When a modifier may not be covered”. Modifier GT - will not be recognized with a minimal office visit for an established patient (99211) added to “When a modifier may not be covered.” Added to Policy Guidelines: BCBSNC does not reimburse for evaluation and management and consultation services provided via telephone, Internet, or other communication network or devices that do not involve direct, in-person patient contact. Revised wording related to modifier 57 from “Modifier - 57 designates the decision to do surgery. It is accepted only with inpatient and observation E&M codes when the decision is made to do a major surgical procedure. A major surgical procedure is defined as one with a 90 day global period. The global period starts the day prior to surgery. The modifier is appropriate to signify that the decision was made to do a major surgery procedure within the global period.” to “Modifier 57 - is an evaluation and management service that results in the initial decision to perform surgery.” from “When a modifier may be covered.” Statement “Modifier -57 will not be recognized with any E&M code other than inpatient or observation” removed from “When a modifier may not be covered”. Medical Policy reviewed 08/17/07 by Senior Medical Director of Provider Partnerships, Medical and Reimbursement Policy.

12/03/07 Reference added to clarify that “Blue Advantage” applies to this policy. Statement, “Modifier -25 will not be recognized with inpatient E&M services.” removed from “When a Modifier may not be covered”.

07/20/09 Added modifier -54, -55, and -56 to “When a Modifier may be covered.” Removed references related to American College of Surgeons. Added nurse practitioner and nurse midwives to modifier “AS”. New modifiers PA, PB and PC are effective 7/1/2009, which describe serious adverse events. Removed references to Blue Advantage, Blue Care, Blue Choice, Blue Options, and Classic Blue Products Policy reviewed by VP/ Senior Medical Director of Provider Partnerships, Medical and Reimbursement Policy.