Massachusetts | Commercial

Commercial Reimbursement Policy	
Subject: **Modifier Usage– Professional**	
Policy Number: **C-08010**	Policy Section: **Coding**
Last Approval Date: **01/16/2024**	Effective Date: **01/16/2024**

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 a Wellpoint 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, Wellpoint 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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, we will publish the most current policy to the website.

Policy

Wellpoint allows reimbursement for covered services provided to eligible members when billed with appropriate procedure codes and appropriate modifiers when applicable unless provider, state, or federal contracts and/or requirements indicate otherwise.

Reimbursement is based on the code-set combinations submitted with the correct modifiers. The use of certain modifiers requires the provider to submit supporting documentation along with the claim. Refer to the specific modifier policies for guidance on documentation submission. We reserve the right to review adherence to correct coding for high-volume modifiers.

Applicable electronic or paper claims billed without the correct modifier in the correct format may be rejected or denied. The modifier must be in capital letters, if alpha or alphanumeric. Rejected or denied claims must be resubmitted with the correct modifier in conjunction with the code-set to be considered for reimbursement. Corrected and resubmitted claims are subject to timely filing guidelines. The use of correct modifiers does not guarantee reimbursement.

Reimbursement Modifiers
Reimbursement modifiers affect payment and denote circumstances when an increase or reduction is appropriate for the service provided. The modifiers must be billed in the primary or first modifier field locator.

Informational Modifiers Impacting Reimbursement
Informational modifiers determine if the service provided will be reimbursed or denied. Modifiers that impact reimbursement should be billed in modifier locator fields after reimbursement modifiers, if any.

Informational Modifiers Not Impacting Reimbursement
Informational modifiers are used for documentation purposes. Modifiers that do not impact reimbursement should be billed in the subsequent modifier field locators. We reserve the right to reorder modifiers to reimburse correctly for services provided.

Related Coding

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

Policy History

01/16/2024	Review approved: policy updated title from Modifier Rules-Professional to Modifier Usage-Professional; added section headers to provide modifier type clarity; updated code list to include related policies
06/08/2022	Review approved 06/08/2022 and effective 12/01/2022: Modifier FT is allowed for reimbursement on critical care codes 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476; added Modifier FT to Modifiers Impacting Adjudication list; added modifier FS to Informational Modifier list
04/13/2022	Review approved 04/13/2022 and effective 10/1/2022: Coding section updated to indicate that reimbursement is not allowed for CPT code 99211 when billed with Modifier 25

11/23/2020	Review approved 11/23/2020 and effective 04/01/2021: updated policy language; added and updated Modifiers definitions and comments, Modifiers added GN, GO, GP, K0, K1, K2, K3 and K4, updated Related Coding Section, and Related Policies and Materials
09/15/2020	Review approved 09/15/2020 and effective 02/01/2021: added Modifier FB to policy; reimbursement is not allowed when appended
06/01/2019	Review approved: policy template updated; description section was removed
03/28/2019	Review approved: adherence to correct coding language added
10/26/2018	Review approved; Modifier definition updated with current CPT Modifier definitions
08/01/2017	Review approved: 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: updated policy language, updated Modifiers Q5 and Q6
02/07/2017	Review approved: 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: updated policy language to include Modifiers BP, BR, EX; added Modifiers BP, BR, EX, updated Modifier NR
04/05/2016	Review approved: updated Modifiers 91, KI, KR, LL, NR, RR
03/01/2016	Review approved: 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 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: updated policy language to include G8, G9, and QS. oved 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 percents; 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: 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: 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: 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: added 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: updated Modifier 25 and 57
06/03/2014	Review approved: 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%; removing reference to Kentucky since this will be adopted by all the local plans as fee schedules are updated, 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; Added Modifier SG—ASC facility service—as not eligible for separate reimbursement; the language is bracketed because there are a few states wherein the ASCs submit on a HCFA and have to report their services with the SG Modifier. This applies to New Hampshire and Wisconsin
02/05/2013	Review approved: added Frequency policy to the reference section
12/03/2013	Review approved: 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; updated Disclaimer, Description section and Modifiers in Policy section, Modifiers added LM, RI,
02/05/2013	Review approved 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: updated Modifiers KC, NR, NU, RA, RB UE
05/01/2012	Review approved: 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.] Added [KENTUCKY ONLY: Problem oriented E/M codes appended with modifier 25 and reported on the same date of service as a preventive exam 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: updated Modifier SU,
03/06/2012	Review approved: added Modifier SU
11/01/2011	Review approved: updated Modifiers 22, 24, 25, 50, 59, 62, 66, 90, PA, PB, PC; added Modifiers 32 & 58
06/07/2011	Review approved: added Modifier QK, QX, QY
03/01/2011	Review approved: 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: 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: updated Modifier 25 revisions in the description section: the policy reference for Claim Editing Overview and Global Surg was removed; just the E/M Modifier 25 policy reference remains. In the Comments Section: the reference that Modifier 25 overrides ME edit for 2 E/M's was removed since it currently does override. The statement that mod 25 does override problem E/M with preventive was added. Modifier 76and 77 revisions. Wording was fixed to indicate current processing. Modifier 21 was deleted; Added modifier AI.
10/26/2009	Review approved: 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: added Modifier 52 and 53
05/04/2009	Review approved: added Modifier 90 to be informational
12/02/2008	Review approved: Informational Modifiers have been separated from Modifiers that Impact Payment.
11/04/2008	Review approved: added Modifiers GC, GE, GR, verbiage for Mod 22 was updated to match CPT
09/18/2008	Review approved: 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:

- CMS
- Optum EncoderPro 2023

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

Ambulance Transportation - Professional
Bundled Services and Supplies – Professional
Code and Clinical Editing – Professional
Claims Requiring Additional Documentation – Professional
Nurse Practitioner (NP), and Physician Assistant Services – Professional
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 & -57 – Professional

Frequency Editing – Professional
Global Surgery – Professional
“Incident To” Services - Professional
Laboratory and Venipuncture Services - Professional
Modifier 22– Professional
Modifier 26 and TC: - Professional
Modifier 62- Professional
Modifier 66- Professional
Modifiers 80, 81, 82, and AS: Assistant at Surgery - Professional
Multiple and Bilateral Surgery Processing – Professional
Multiple Delivery Services – Professional
Multiple Diagnostic Imaging Procedures – Professional
Multiple Procedure Payment Reduction - Professional
Pharmaceutical Waste – Professional and Facility
Place of Service – Professional
Professional Anesthesia Services
Provider Preventable Conditions- Professional and Facility
Screening Services with Related Evaluation and Management Services- Professional
Split Care Surgical Modifiers - Professional
Virtual Visits - Professional and Facility

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.