Professional Pricing Policy

Subject: **Modifier Rules**	
Policy Number HLCP-0008	Policy Section: **Coding**
Last Approval Date: September 1, 2024	Effective Date: December 1, 2024

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for allowed amounts for HealthLink members. 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. 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. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines are not followed, HealthLink and/or its Payors may:

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

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates.

We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or adjust pricing accordingly to the effective date. HealthLink reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to the website. Note: medical claim pricing and processing services provided by HealthLink are available to a payor; however not all payors purchase such services for the benefit plans they sponsor.

Policy

HealthLink accepts for claims processing, but not always to determine allowance, all HIPAA compliant CPT and HCPCS modifiers. HealthLink 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 AMA CPT or The Centers for Medicare & Medicaid Services (CMS) when reporting modifiers.

HealthLink also uses its claim editing system for modifier to procedure code validation. Our claim editing system identifies if 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. HealthLink validates that the following modifiers are appropriately used with procedure codes: 22, 24, 25, 26, 50, 52, 53, 54, 55, 56, 57, 59, 62, 63, 76, 77, 78, 79, 80, 81, 82, 91, 95, AD, AS, BP, BR, CT, E1-E4, EX, F1-F9, FA, G8, G9, KC, KI, KR, LC, LD, LL, LM, LT, MS, NR, NU, P3, P4, P5, QK, QS, QX, QY, QZ, RA, RB, RC, RI, RR, RT, SA, T1-T9, TA, TC, UE, XE, XP, XS, and XU. 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. HealthLink 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, HealthLink 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, HealthLink will consider the additional procedure(s) to be same site as the modified procedure which may result in the subsequent procedure(s) being denied.

When multiple modifiers that apply a percentage amount to the maximum allowance are reported with a procedure, our claim editing system will multiply the percentage amounts together to determine a new

percentage amount. When the new percentage amount contains a decimal place, our claim editing system will round the new percentage amount up to the next whole percentage and apply this whole percentage amount to the maximum allowance for the procedure the modifiers are reported with.

In addition to modifier to procedure code validation, the following modifiers are used in the adjudication of a claim and may impact allowed amount.

Related Coding

Modifier	Description	Comments
22	Increased Procedural Services	• Procedure codes reported with modifier 22 without operative notes/office notes will be allowed based on the maximum allowance for the procedure code, without review for additional allowance. • Procedure codes reported with modifier 22 with operative notes/office notes will be reviewed to determine if additional allowance is warranted. • 120% (if approved) allowed
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Post Operative Period*	• When appended to an E/M procedure code, modifier 24 may override a surgical aftercare edit and the reported E/M code may be allowed.
25	Significant, Separately Identifiable * Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service*	When appended to an E/M procedure code, modifier 25 may override the following edits and the reported E/M code may allowed: • Same Day medical visit with a procedure or service. • A problem oriented E/M code reported on the same day as a preventive E/M code by the same provider and modifier 25 is appended to either the problem oriented or preventive E/M code.
26	Professional Component	• Allowance is based on the professional component of a procedure that has both a technical and professional component.

Modifier	Description	Comments
50	Bilateral Procedures	• Bilateral surgical services are subject to the multiple surgery pricing rules. The surgical CPT code is required to be reported on one line with modifier 50 appended. • Allowance is made at the rate of 100% for the first side and 50% for the second side (100 +50=150%). • Diagnostic services, including radiology, are not subject to multiple surgery pricing rules. Therefore, bilateral procedures for this type of service are to be reported on two lines with the LT and RT site-specific modifiers. • When modifier 50 is reported with a procedure that includes "bilateral" or "unilateral or bilateral" in the description, the procedure will not be allowed. • 150% allowed
52	Reduced Services	• Procedure codes reported with modifier 52 are processed and priced at 50% of the allowance.
53	Discontinued Procedure	• . Procedure codes reported with modifier 53 are processed and priced at 50% of the allowance.
54	Surgical Care Only*	• Surgical procedures reported with modifier 54 are priced at 70% of the allowance. • Allowed amount is applied to the surgical procedure only. • This lower % rate carves out the preop and post op care which is usually included in the global surgical allowance for a surgical procedure. • This modifier is reported with the surgical code when one provider performs the surgical procedure and another provides the pre-operative and/or post- operative care.
55	Post-Operative Management Only	• Surgical procedures reported with modifier 55 are priced at 20% of the allowance. • This lower % rate carves out the preoperative visit and the surgery, which are usually included in the global allowance for a surgical procedure. • This modifier is reported with the surgical code when one provider performed the postoperative care and another performed the surgical procedure. • Procedures with zero post-operative care days reported with modifier 55 will not be allowed.

Modifier	Description	Comments
56	Preoperative Management Only	• Surgical procedures reported with modifier 56 are priced at 10% of the allowance. • Remove extra space • This lower % rate carves out the surgery and post- operative care, which are usually included in the global allowance for a surgical procedure. • This modifier is reported with the surgical code when one provider performed the pre-operative care and another performed the surgery.
57	Decision For Surgery	• When the decision for surgery is made one day prior to or on the day of a major surgical procedure and modifier 57 is appended to a reported E/M code, the modifier will override the one-day prior or the same day pre-op medical visit edit for the major surgical procedure ("90" day global period) and the reported E/M code may be allowed
59	Distinct Procedural Service*	• Modifier 59 will, in many cases, affect the adjudication of the reported code by overriding incidental, mutually exclusive, and rebundle edits, allowing the reported procedure code to be separately allowed. • This modifier will <u>not</u>: ○ override some edits listed as "always bundled" in the Bundled Services and Supplies Professional Pricing Policy ○ override an edit for a code listed in the "Exceptions to Modifier 59 Override" the Modifier 59 Professional Pricing Policy ○ override a duplicate procedure edit ○ override frequency edit limits
62	Two Surgeons (Co-Surgery)	• When two surgeons act as co-surgeons, each surgeon's claim is priced at 63% of the allowance for an individual code. • This lower allowance reflects the shared responsibility for global surgical services.
63	Procedure performed on infants less than 4kg Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine Services sections in CPT	Procedures reported with modifier 63 are eligible for additional allowance except for: • those services noted in the modifier 63 description that should not be appended with modifier 63 (for example E/M services or radiology) • 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 • 120% percentage allowed

Modifier	Description	Comments
66	Surgical Team	• This modifier has no effect on the allowance of the reported surgical code, but is important to establish team surgery status in the performance of the procedure.
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional	• When appended to a procedure code, modifier 76 indicates that the repeated procedure/service is not a duplicate. • A claim may be reviewed to determine the eligibility for separate allowance for the repeated procedure code.
77	Repeat Procedure or Service by Another Physician or Other Qualified Health Care Professional	• When appended to a procedure code, modifier 77 indicates that the repeated procedure/service is not a duplicate. • A claim may be reviewed to determine the eligibility for separate allowance for the repeated procedure code.
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period	• Surgical procedures reported with this modifier are priced at 70% of the allowance. • This lower % rate carves out the pre-op and post-op- care which is usually included in the global surgical allowance for a surgical procedure.
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Post Operative Period	• When appended to a procedure or service, modifier 79 will override global surgical editing and the reported procedure code may be allowed.
80	Assistant Surgeon	• Surgical procedures reported with modifier 80 are priced at 16% of the total allowance for the reported code. • Modifier 80 should not be used to report assistant surgeon services rendered by non-physician providers.
81	Minimum Assistant Surgeon	• Surgical procedures reported with modifier 81 are priced at 16% of the total allowance for the reported code. • Modifier 81 should not be used to report minimum assistant surgeon services rendered by non-physician providers.
82	Assistant Surgeon (When Qualified Resident Surgeon Not Available)	• Surgical procedures reported with modifier 82 are priced at 16% of the total allowance for the reported code. • Modifier 82 should not be used to report assistant surgeon services rendered by non-physician providers.

Modifier	Description	Comments
91	Repeat Clinical Diagnostic Laboratory Test	• When modifier 91 is appended to a reported laboratory procedure code, our claims editing system will override a frequency edit and allow separately for the repeat clinical diagnostic laboratory test except as described in our Frequency Editing Professional Pricing Policy. • Modifier 91 will not override component code editing for laboratory organ or disease- oriented panels.
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System	• Modifier 95 is to be used with CPT codes identified in Appendix P of the CPT codebook.
99	Multiple Modifiers	
AD	Medical Supervision by a Physician: More than four concurrent anesthesia procedures	
AS	Physician Assistant, Registered Nurse First Assistant, Nurse Practitioner or Clinical Nurse Specialist Services for Assistant at Surgery	• Surgical procedures reported with modifier AS are priced at 14% of the total allowance for the reported code. • Modifier AS is to be used for reporting assistant-at- surgery services by non-physician providers.
BP	The beneficiary has been informed of the purchase and rental options and has elected to purchase the item	• This modifier is used when the provider has discussed the purchase/rent option with the patient and the patient has chosen to purchase the DME item.
BR	The beneficiary has been informed of the purchase and rental options and has elected to rent the item	• This modifier is used when the provider has discussed the purchase/rent option with the patient and the patient has chosen to rent the DME item.
CC	Procedure Code Change	• This modifier is used when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed
CT	Computed tomography services furnished using equipment that does not meet each of the attributes of the national electrical manufacturers association (NEMA) r-29-2013 standard	• Computed tomography services that are furnished on non-NEMA Standard XR-29-2013-compliant CT equipment must include modifier "CT"
E1-E4	Eyelids	• These site-specific modifiers are recognized by our claim editing system, and may override applicable edits.

Modifier	Description	Comments
EX	Expatriate beneficiary	• This modifier is used when certain durable medical equipment is eligible for reimbursement for those Medicare beneficiaries with permanent addresses outside of the United States for whom items were furnished while the beneficiary was in the United States.
F1-F9, FA	Hand, Digit/Thumb	• These site-specific modifiers are recognized by our claim editing system, and may override applicable edits.
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure	• When modifier G8 is reported with a general anesthesia service, the general anesthesia service will not be allowed. Modifier G8 is considered informational only to indicate monitored anesthesia care (MAC) and is to be reported in a subsequent modifier field when reported with any servicing modifier
G9	Monitored anesthesia care for patient who has history of severe cardiopulmonary condition	• When modifier G9 is reported with a general anesthesia service, the general anesthesia service will not be allowed; or • Modifier G9 is considered informational only to indicate monitored anesthesia care (MAC) and is to be reported in a subsequent modifier field when reported with any servicing modifier
KC	Replacement of Special Power Wheelchair Interface	• Modifier KC is required for replacement of special power wheelchair interface
KI	DMEPOS Item, 2nd or 3rd month rental	• Orthotics and prosthetics classified as purchase only items when reported with rental modifiers.
KR	Rental Item, Billing for Partial Month	• Orthotics and prosthetics classified as purchase only items when reported with rental modifiers.
LC	Left circumflex coronary Artery	• This site-specific modifier is recognized by our claim editing system
LD	Left Anterior Descending Coronary Artery	• This site-specific modifier is recognized by our claim editing system
LL	Lease/Rental (Use when DME equipment rental is to be applied against the purchase price)	• Orthotics and prosthetics classified as purchase only items when reported with rental modifiers.
LM	Left Main Coronary Artery	• This site-specific modifier is recognized by our claim editing system
LT	Left Side (used to identify procedures performed on the left side of the body)	• This site-specific modifier is recognized by our claim editing system. When modifier LT is reported with a procedure that includes “bilateral” or “unilateral or bilateral” in the description, the procedure code will not be allowed.

Modifier	Description	Comments
MS	Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty	• A DME item that is eligible for maintenance is recognized by our claim editing system
NR	New when rented (use the NR modifier when DME which was new at the time of rental is subsequently purchased)	• Modifier NR is required for an item purchased when the item was originally rented as a new item. • Certain rent-to-purchase DME items are not routinely purchased up-front and must be reported with the appropriate DME rental modifier; these rent to purchase items should be billed with purchase modifier NR.
NU	New equipment—purchase	• Modifier NU is required for items purchased. • Certain rent-to-purchase DME items are not routinely purchased up-front and must be reported with the appropriate DME rental modifier.
P3, P4, P5	Anesthesia Physical Status Modifiers	• Anesthesia codes reported with the modifiers P3, P4, or P5 are eligible for additional unit allowance as follows: P3 = 1 unit, P4 = 2 units P5 = 3 units
PA	Surgery of other invasive procedure on wrong body part	• Procedures with this modifier may be denied.
PB	Surgery or other invasive procedure on wrong patient	• Procedures reported with this modifier may be denied.
PC	Wrong surgery or other invasive procedure on patient	• Procedures reported with this modifier may be denied.
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	• The 50% allowed amount for medical direction carves out the allowance for the qualified professional who actually administered the anesthesia service.
QS	Monitored anesthesiology care services (can be billed by a qualified nonphysician anesthetist or a physician)	• Modifier QS is considered informational only to indicate monitored anesthesia care (MAC) and is to be reported in a subsequent modifier field when reported with any servicing modifier
QX	Qualified nonphysician anesthetist with medical direction by a physician	• The 50% allowed amount for medical direction carves out the allowance for the qualified professional who actually administered the anesthesia service.
QY	Medical direction of one qualified nonphysician anesthetist by an anesthesiologist	• The 50% allowed amount for medical direction carves out the allowance for the qualified professional who actually administered the anesthesia service.

Modifier	Description	Comments
QZ	CRNA Service without medical direction by a physician* (*See Anesthesia Pricing Policy)	• Procedures reported with this modifier are priced at 85% of the allowance.
RA	Replacement of a DME, Orthotic, or Prosthetic Item	• Replacement of approved medically necessary member owned DME equipment may be allowed except when replacement is due to damage, neglect, misuse, or mistreatment of the equipment by the member • Replacement of HealthLink-defined "frequently serviced" DME items will be denied. HealthLink requires frequently serviced DME items to be rented, and repair and/or replacement of these items is included in the rental fee.
RB	Replacement of a Part of a DME, Orthotic, or Prosthetic Item Furnished as Part of a Repair	• Reasonable and necessary repairs or replacement part of approved medically necessary member-owned equipment may be allowed **except** when the cost of repairs and/or replacement part(s) will exceed the allowance for the purchase of member-owned equipment or when the required repairs are due to damage, neglect, misuse or mistreatment of the equipment by the member. • Replacement of parts of HealthLink-defined "frequently serviced" DME items will be denied. HealthLink requires frequently serviced DME items to be rented, and repair and/or replacement of these items is included in the
RC	Right Coronary Artery	
RI	Ramus Intermedius Coronary Artery	• This site-specific modifier is recognized by our claim editing system, and may override applicable edits.
RR	Rental (Use the RR modifier when DME is to be rented)	• Monthly rental is equivalent to 1/10th of the maximum allowance for a purchase. • Orthotics and prosthetics classified as purchase only items will not be allowed when reported with rental modifiers. • DME items (e.g., E0100-E9999 and K0001- K0902) reported with rental modifier RR with place of service office (11) or urgent care facility (20) will not be allowed.
RT	Right Side (used to identify procedures performed on the right side of the body)	• This site-specific modifier is recognized by our claim editing system, and may override applicable edits. • When modifier RT is reported with a procedure that includes "bilateral" or "unilateral or bilateral" in the description, the procedure will not be allowed

Modifier	Description	Comments
SA	Nurse practitioner, physician assistant, clinical nurse specialist, or an advanced practice professional provides services in collaboration with a physician.	• Non-surgical procedures reported with this modifier are priced at 85% of the allowance.
SG	Ambulatory surgical center (ASC) facility service	• Information only
SL	State Supplied Vaccine	• A vaccine supplied by a state government agency at no cost to the provider • Informational only
SU	Procedure performed in physician's office (to denote use of facility and equipment).	• Procedures reported with modifier SU are for 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.
T1-T9, TA	Left/Right Foot, Digit, Great Toe	• These site-specific modifiers are recognized by our claim editing system, and may override applicable edits.
TC	Technical Component Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier 'TC' to the usual procedure number.	• Reimbursement is based on the technical component of a procedure that has both a technical and professional component.
UE	Used durable medical equipment	• Modifier UE is required for item to be allowed for purchase. • Certain rent-to-purchase DME items (e. g., E0601 (CPAP/APAP); E0470, E0471 (BPAP); E0561, E0562 (humidifiers)), are not routinely purchased up-front and must be reported with the appropriate DME rental modifier
XE	Separate encounter, service that is distinct because it occurred during a separate encounter	
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner	
XS	Separate structure, a service that is distinct because it was performed On A Separate organ/structure	
XU	Unusual non-overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service	

The following table lists some (but not all) commonly reported modifiers that the HealthLink considers "Informational only". These modifiers have no effect on the maximum allowance of the reported code.

Modifier	Description	Comments
23	Unusual Anesthesia*	• Informational only with no additional compensation. This modifier has no effect on the allowance of the reported anesthesia code. • The provider should append the appropriate physical status modifier P1-P6 to indicate a specific physical condition.
32	Mandated Services	• Informational only. This modifier has no effect on the maximum allowance for a covered procedure code.
33	Preventive Service	• Preventative Services Information only
47	Anesthesia by Surgeon	• Informational only with no additional compensation. This modifier has no effect on the maximum allowance for the reported procedure code.
51	Multiple Procedures	• Informational only. This modifier has no effect on the maximum allowance for the reported procedure code. • HealthLink determines the ranking for applying multiple surgery pricing rules through its claim processing system not through the use of this modifier.
58	Staged or related procedure or service by the same physician during the postoperative period	• Informational only.
90	Reference (Outside) Laboratory	• Informational only.
92	Alternative Laboratory Platform Testing	• Informational only.
AA	Anesthesia Services Performed Personally by Anesthesiologist	• Informational only. This modifier has no effect on the allowance for the reported anesthesia code.
AI	Principal physician of record	• Informational only.
GC	This service has been performed in part by a resident under the direction of a teaching physician	• Informational only.
GE	This service has been performed by a resident without the presence of a teaching physician under the primary care exception	• Informational only.
GR	This service was performed in whole or in part by a resident in a Department of Veterans Affairs Medical Center or clinic, supervised in accordance with VA policy.	• Informational only.
P1, P2, P6	Anesthesia Physical Status Modifiers*	• Informational only. • Anesthesia codes reported with modifier P1, P2, or P6 are not eligible for additional unit allowance.
PT	Colorectal cancer screening test	• Informational only

	converted to a diagnostic test	
QL	Patient Pronounced Dead After Ambulance Called	• Informational only
Modifier	**Description**	**Comments**
Q5	Service furnished under a reciprocal billing arrangement by a substitute physician; or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area	• Informational only
Q6	Service furnished under a fee-for- time compensation arrangement by a substitute physician; or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area	• Informational only

Exemptions

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.
General Professional Pricing Policy Definitions	

Related Policies and Materials

Anesthesia Services
Assistant Surgeon Services
Bundled Services and Supplies
Claim Editing Overview
Claims Requiring Additional Documentation
Co-Surgeon/Team Surgeon Services
Documentation and Reporting Guidelines for Evaluation and Management Services
Evaluation and Management Services and Related Modifiers -25 & -57
Frequency Editing
Global Surgery
Laboratory & Venipuncture Services
Modifier 22 (Increased Procedural Services)
Modifiers 59 and XE, XP, XS, & XU
Multiple and Bilateral Surgery Processing
Place of Service

References and Research Materials

This policy has been developed through consideration of the following

- CMS
- AMA Medical Record Auditor
- American Medical Association (AMA) Current Procedural Terminology (CPT)

Use of Pricing Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Pricing Policy is constantly evolving and we reserve the right to review and update these policies periodically.