Payment Policy: Modifier to Procedure Code Validation

Reference Number: CC.PP.028
Product Types: ALL
Effective Date: 01/01/2013
Last Review Date: 11/30/2021

Coding Implications
Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Policy Overview
Providers append modifiers to procedure codes to indicate that a procedure or service has been altered by some circumstance, but the definition of the procedure or the procedure code itself is unchanged.

When a provider bills a modifier that is invalid for the procedure code billed, the claim line containing the invalid modifier to procedure code combination is denied. This policy is relevant to modifiers identified as affecting payment.

The Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and public-domain specialty societies determine payment modifiers that are appropriate for billing with certain procedure codes. The AMA publishes the Current Procedural Terminology (CPT) HCPCS Level I modifiers and CMS publishes the valid list of HCPCS Level II modifiers.

According to the AMA (2021):
A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but has not changed in its definition or code. Modifiers also enable healthcare professionals to effectively respond to payment policy requirements established by other entities (p. 709).

Application
This policy applies to Professional and Outpatient institutional claims.

Policy Description

Reimbursement
Claims Reimbursement Edit
The health plan's code editing software evaluates individual claim lines for invalid payment modifier to procedure code combinations.

The rule denies procedure codes when billed with a payment modifier that is inappropriate for the service billed or not clinically likely for the procedure code billed.

This rule reviews modifier to procedure code combinations on the current claim only and does not review historical claims.

Rationale for Edit

Providers should bill the correct payment modifier for the appropriate procedures.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Modifier	Descriptor
22	Increased Procedural Services
23	Unusual Anesthesia
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period
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
26	Professional Component
27	Multiple Outpatient Hospital E/M Encounters on the Same Date
32	Mandated Services
33	Preventive Service
47	Anesthesia by Surgeon
50	Bilateral Procedure
51	Multiple Procedures
52	Reduced Services
53	Discontinued Procedure
54	Surgical Care Only
55	Postoperative Management Only
56	Preoperative Management Only
57	Decision for Surgery
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period
59	Distinct Procedural Service
62	Two Surgeons
63	Procedure Performed on Infants less than 4 kg
66	Surgical Team
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia

74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
77	Repeat Procedure or Service by Another Physician or Other Qualified Health Care Professional
78	Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician During the Postoperative Period
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).
90	Reference (Outside) Laboratory
91	Repeat Clinical Diagnostic Laboratory Test
92	Alternative Laboratory Platform Testing
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
96	Habilitative Services
97	Rehabilitative Services
99	Multiple Modifiers
AA	Anesthesia Services Performed Personally by Anesthesiologist
AD	Medical Supervision by a Physician: More than 4 Concurrent Anesthesia Procedures
AR	Physician Provider Services in a Physician Scarcity Area
AS	Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Services for Assistant at Surgery
QK	Medical direction of two, Three, or four concurrent anesthesia procedures involving qualified individuals.
QS	Monitored anesthesia care service
QW	CLIA Waived Test
QX	CRNA Service : With Medical Direction by a Physician
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist.
QZ	CRNA Service: Without medical direction by a physician
TC	Technical Component
XE	Separate encounter, a 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

Definitions

1. ***HealthCare Common Procedure Coding System*** (HCPCS), Level I Modifiers: Also known as CPT modifiers consisting of two numeric digits. These modifiers are in the range of 22-99. The list is updated annually by the AMA.
2. ***HealthCare Common Procedure Coding System*** (HCPCS), Level II Modifiers: Also known as the HCPCS modifiers and consist of two alpha-numeric characters. These modifiers are in the range of AA-VP. The list is updated annually by the CMS.
3. ***Modifier***: Two digit numeric or alpha-numeric descriptor that is used by providers to indicate that a service or procedure has been altered by a specific circumstance, but the procedure code and definition is unchanged.
4. ***Modifiers Affecting Payment***: Modifiers which impact how a claim or claim line will be reimbursed.

Related Policies

- CC.PP.013 Clinical Validation of Modifier -25
- CC.PP.014 Clinical Validation of Modifier -59
- CC.PP.020 Distinct Procedural Modifiers

Related Documents or Resources

Not Applicable

References

1. *Current Procedural Terminology (CPT®)*, 2021
2. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS
3. *HCPCS Level II*, 2021
4. *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM), 2021
5. *ICD-10-CM Official Draft Code Set*, 2021
6. *Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.*

Revision History	
09/09/2016	Corrected Modifier definitions for QW and QX
02/24/2018	Converted to updated template, conducted review, removed Modifier -21; Added Modifiers: -23,-32,-47,-63,-77,-90,-92,-95,-96,-97,-99,-QS,-XO,-XP,-XS,-XU
04/01/2019	Conducted review, verified codes , updated policy
11/01/2019	Annual Review completed

11/01/2020	Annual Review completed
11/30/2021	Annual review completed; links updated

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

 Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence.

Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.