CENTENE Corporation

Payment Policy: Modifier Date of Service Validation

Reference Number: CC.PP.034
Product Types: ALL
Effective Date: 01/01/2013
Last Review Date: 11/04/2025

Coding Implications
Revision Log

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

Policy Overview
Medical Coding Modifiers are two characters appended to procedure codes to provide additional details about the medical procedure, service(s) or supply that was performed without changing or altering the American Medical Association (AMA) Current Procedural Terminology (CPT) definition of the procedure or the procedure code. The AMA publishes the list of HCPCS Level I (CPT) Modifiers, while CMS publishes the list of HCPCS Level II Modifiers.

When a provider bills a modifier that is invalid for the date a procedure or service was performed, the claim line containing the invalid modifier will be denied.

According to the AMA:
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.

Application
This policy applies to Professional and Outpatient institutional claims.

Reimbursement
The health plan's code editing software evaluates individual claim lines for invalid or expired modifiers. The modifier is validated by the software against reference logic that includes current Level I and Level II HCPCS modifiers. If a claim line billed with a modifier is found to be invalid or expired on the date of service, it is refused.

Modifier validity is assessed solely for current claims, not previous claims.

Rationale for Edit
Correct and valid modifiers should be appended for the date that services are rendered.

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 2026, 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.

References

1. *Current Procedural Terminology (CPT®)*, 2026
2. *HCPCS Level II*, 2026
3. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS
4. https://www.ama-assn.org/system/files/reporting-CPT-modifier-25.pdf
5. https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update

Revision History	
02/24/2018	Converted to new template and conducted review; revised the list to include A1-A9; and ZA-ZC
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
12/01/2022	Annual review completed; removed definitions to eliminate redundancies and removed code tables as this information can be found within listed references
12/01/2023	Annual review completed; removed AMA page number 709 from document on "According to the AMA" as well as removed the year. Added reference number 6, AMA Reporting CPT Modifier 25 as page 2 has verbiage for modifiers according to the AMA.
03/06/2024	Annual review completed; added CMS https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update ; updated policy overview to make and provide clarification on Modifiers; when to use them based on AMA.
11/22/2024	Annual review completed; references validated.
11/05/2025	Annual Review completed; Validated policy content, references and links; Added revision date

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.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. 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.

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