Modifier Reference Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, the enrollee's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

Application

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

According to the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS), 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 not changed in its definition or code. It may also provide more information about a service such as it was performed more than once, unusual events occurred, or it was performed by more than one physician and/or in more than one location.

This document is a reference tool to guide readers to reimbursement policies in which modifiers are addressed. For complete information, please refer to the specific reimbursement policy that pertains to your coding situation.

For information regarding the appropriate use of modifiers with individual CPT and HCPCS procedure codes refer to the Procedure to Modifier Policy.

Note: The lists below represent modifiers that are addressed in UnitedHealthcare reimbursement policies. It is not an all-inclusive list of CPT and HCPCS modifiers.

Modifier Reference Tables

Modifier	Description	Industry Standards for usage according to AMA publications *Coding with Modifiers* and *Current Procedural Terminology*	Refer to Reimbursement Policy
22	Increased Procedural Services	This modifier should not be appended to an E/M service.	Anesthesia, Increased Procedural Services, Obstetrical, Robotic Assisted Surgery
23	Unusual Anesthesia		Anesthesia
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period	This modifier is only used with E/M services in the CPT codebook. It is not used in any other section of the CPT codebook.	CCI Editing, Global Days, Obstetrical
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	Modifier 25 should be used with E/M codes only and not appended to the surgical procedure code(s).	CCI Editing, Global Days, Injection and Infusion Services, Obstetrical, Preventive Medicine & Screening, Prolonged Services, Rebundling, Same Day Same Service
26	Professional Component		MPPR Diagnostic Imaging, Multiple Procedure Payment Reduction, Obstetrical, Professional/Technical Component
27	Multiple Outpatient Hospital E/M Encounters on the Same Date	This modifier is approved for ambulatory surgery center (ASC) hospital outpatient use	Services and Modifiers Not Reimbursable to Healthcare Professionals
47	Anesthesia by Surgeon	Modifier 47 would not be used as a modifier for the anesthesia procedures.	Anesthesia
50	Bilateral Procedure		Bilateral Procedures, Co-Surgeon/Team Surgeon, Maximum Frequency per Day, Multiple Procedure Payment Reduction, One or More Sessions, Rebundling
51	Multiple Procedures		Multiple Procedure Payment Reduction
52	Reduced Services		Bilateral Procedures, One or More Sessions, Reduced

			Services, Time Span Codes
53	Discontinued Procedure		Discontinued Procedure, Multiple Procedure Payment Reduction, Once in a Lifetime Procedures, One or More Sessions
54	Surgical Care Only		One or More Sessions, Split Surgical Package
55	Postoperative Management Only		Once in a Lifetime Procedures, One or More Sessions, Split Surgical Package
56	Preoperative Management Only		Once in a Lifetime Procedures, One or More Sessions, Split Surgical Package
57	Decision for Surgery	Modifier 57 is used only with an E/M service.	CCI Editing, Global Days, Rebundling
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period		CCI Editing, Global Days, Once in a Lifetime Procedures, Rebundling
59	Distinct Procedural Service	This modifier should not be appended to an E/M service.	Anesthesia, Bilateral Procedures, CCI Editing, Intensity Modulated Radiation Therapy, Laboratory Services, Maximum Frequency per Day, MPPR Diagnostic Imaging, Obstetrical, Professional/Technical Component, Rebundling, Time Span Codes
62	Two Surgeons		Co-Surgeon/Team Surgeon, Multiple Procedure Payment Reduction
63	Procedure Performed on Infants less than 4kg	This modifier should not be appended to any CPT code listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections.	Increased Procedural Services
66	Surgical Team		Co-Surgeon/Team Surgeon, Multiple Procedure Payment Reduction
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia	This modifier is approved for ambulatory surgery center (ASC) hospital outpatient use	Services and Modifiers Not Reimbursable to Healthcare Professionals

74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia	This modifier is approved for ambulatory surgery center (ASC) hospital outpatient use	Services and Modifiers Not Reimbursable to Healthcare Professionals
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional	This modifier should not be appended to an E/M service. For repeat laboratory tests performed on the same day, use modifier 91. For multiple specimens/sites use modifier 59.	Anesthesia, Laboratory Services, Maximum Frequency per Day, MPPR Diagnostic Imaging, Obstetrical, Professional/Technical Component, Time Span Codes
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional	This modifier should not be appended to an E/M service. For repeat laboratory tests performed on the same day, use modifier 91. For multiple specimens/sites use modifier 59.	Anesthesia, Laboratory Services, Obstetrical, Professional/Technical Component
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		Anesthesia, CCI Editing, Global Days, Multiple Procedure Payment Reduction, Rebundling
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period		Anesthesia, CCI Editing, Global Days, One or More Sessions, Rebundling
80	Assistant Surgeon		Assistant Surgeon, Co-Surgeon/Team Surgeon, Multiple Procedure Payment Reduction
81	Minimum Assistant Surgeon		Assistant Surgeon, Co-Surgeon/Team Surgeon, Multiple Procedure Payment Reduction
82	Assistant Surgeon (when qualified resident surgeon not available)		Assistant Surgeon, Co-Surgeon/Team Surgeon, Multiple Procedure Payment Reduction
90	Reference (Outside) Laboratory		Laboratory Services
91	Repeat Clinical Diagnostic Laboratory Test		CCI Editing, Laboratory Services, Maximum Frequency per Day, Professional/Technical Component, Rebundling

92	Alternative Laboratory Platform Testing		Laboratory Services
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System		Telemedicine
AA	Anesthesia services performed personally by anesthesiologist		Anesthesia
AD	Medical supervision by a physician: more than 4 concurrent anesthesia procedures		Anesthesia
AS	Physician Assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery		Assistant Surgeon, Co-Surgeon/Team Surgeon, Multiple Procedure Payment Reduction
E1- E4	Anatomic modifiers which are associated with the eyelid		CCI Editing, Maximum Frequency per Day, Professional/Technical Component, Rebundling
FA, F1- F9	Anatomic modifiers which are associated with the fingers		Bilateral, CCI Editing, Maximum Frequency per Day, Professional/Technical Component, Rebundling
G0	Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke		Telemedicine
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure		Anesthesia
G9	Monitored anesthesia care for patient who has history of severe cardiopulmonary condition		Anesthesia
GC	This service has been performed in part by a resident under the direction of a teaching physician		Anesthesia
GN	Service delivered under an outpatient speech language pathology plan of care		Physical Medicine & Rehabilitation: Speech Therapy, Maximum Combined Frequency Per Day, Multiple Therapy Procedure Reduction

GO	Service delivered under an outpatient occupational therapy plan of care		Physical Medicine & Rehabilitation: PT, OT and Evaluation & Management, Maximum Combined Frequency Per Day, Multiple Therapy Procedure Reduction
GP	Service delivered under an outpatient physical therapy plan of care		Physical Medicine & Rehabilitation: PT, OT and Evaluation & Management, Maximum Combined Frequency Per Day, Multiple Therapy Procedure Reduction
GQ	Via asynchronous telecommunications system		Telemedicine
GT	Via interactive audio and video telecommunications systems		Telemedicine
H9, HU, HV, HW, HX, HY, HZ, QJ, SE, SL, TR	Modifiers which represent services that are funded by a county, state or federal agency		Services and Modifiers Not Reimbursable to Healthcare Professionals
KH, KI, KJ, KM, KN, KR, KX, MS, NR, NU, RR, UE	Modifiers associated with Durable Medical Equipment and Orthotic/Prosthetic Devices		Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency, Supply
LC, LD, LM, RC, RI	Anatomic modifiers which are associated with the coronary arteries		CCI Editing, Maximum Frequency per Day, Professional/Technical Component, Rebundling
LT	Left side (used to identify procedures performed on the left side of the body)		Bilateral Procedures, CCI Editing, Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency, Maximum Frequency Per Day, One or More Sessions, Professional/Technical Component, Rebundling
P1	A normal healthy patient	All anesthesia services are reported by use of the anesthesia five-digit procedure code (00100-01999) with the appropriate physical status modifier appended.	Anesthesia
P2	A patient with mild systemic disease	All anesthesia services are reported by use of the anesthesia five-digit procedure code (00100-01999) with the appropriate physical status modifier appended.	Anesthesia

P3	A patient with severe systemic disease	All anesthesia services are reported by use of the anesthesia five-digit procedure code (00100-01999) with the appropriate physical status modifier appended.	Anesthesia
P4	A patient with severe systemic disease that is a constant threat to life	All anesthesia services are reported by use of the anesthesia five-digit procedure code (00100-01999) with the appropriate physical status modifier appended.	Anesthesia
P5	A moribund patient who is not expected to survive without the operation	All anesthesia services are reported by use of the anesthesia five-digit procedure code (00100-01999) with the appropriate physical status modifier appended.	Anesthesia
P6	A declared brain-dead patient whose organs are being removed for donor purposes	All anesthesia services are reported by use of the anesthesia five-digit procedure code (00100-01999) with the appropriate physical status modifier appended.	Anesthesia
PA	Surgical or other invasive procedure on wrong body part		Wrong Surgical or Other Invasive Procedures
PB	Surgical or other invasive procedure on wrong patient		Wrong Surgical or Other Invasive Procedures
PC	Wrong surgery or other invasive procedure on patient		Wrong Surgical or Other Invasive Procedures
PO	Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments		Services and Modifiers Not Reimbursable to Healthcare Professionals
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals		Anesthesia
QS	Monitored anesthesia care service		Anesthesia
QX	CRNA service: with medical direction by a physician		Anesthesia
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist		Anesthesia

QZ	CRNA service: without medical direction by a physician		Anesthesia
RT	Right side (used to identify procedures performed on the right side of the body)		Bilateral Procedures, CCI Editing, Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency, Maximum Frequency Per Day, One or More Sessions, Professional/Technical Component, Rebundling
SG	Ambulatory surgical center (ASC) facility service		Not applicable – refer to the Questions and Answers section of this policy
SU	Procedure performed in physician's office (to denote use of facility and equipment)		Modifier SU
TA, T1 - T9	Anatomic modifiers which are associated with the toes		Bilateral, CCI Editing, Maximum Frequency per Day, Professional/Technical Component, Rebundling
TC	Technical Component		MPPR Diagnostic Imaging, Multiple Procedure Payment Reduction, Professional/Technical Component
XE	Separate encounter, a service that Is distinct because it occurred during a separate encounter	HCPCS modifiers for selective identification of subsets of Distinct Procedural Services [-59 modifier]	Anesthesia, CCI Editing, Laboratory Services, Maximum Frequency per Day, MPPR Diagnostic Imaging, Professional/Technical Component, Rebundling
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner	HCPCS modifiers for selective identification of subsets of Distinct Procedural Services [-59 modifier]	CCI Editing, Laboratory Services, Professional/Technical Component, Rebundling
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure	HCPCS modifiers for selective identification of subsets of Distinct Procedural Services [-59 modifier]	Bilateral Procedures, CCI Editing, Laboratory Services, Maximum Frequency per Day, Professional/Technical Component, Rebundling
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service	HCPCS modifiers for selective identification of subsets of Distinct Procedural Services [-59 modifier]	Anesthesia, CCI Editing, Intensity Modulated Radiation Therapy, Laboratory Services, Maximum Frequency per Day, Professional/Technical Component, Rebundling

Reimbursement Policy	Modifiers addressed within the reimbursement policy
Anesthesia	22, 23, 47, 59, 76, 77, 78, 79, AA, AD, GC, G8, G9, QK, QS, QX, QY, QZ, P1 - P6, XE, XU
Assistant Surgeon	80, 81, 82, AS
Bilateral Procedures	50, 52, 59, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, LT, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, XS
CCI Editing	24, 25, 57, 58, 59, 78, 79, 91, E1, E2, E3, E4, LC, LD, LM, LT, RC, RI, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, FA, F1, F2, F3, F4, F5, F6, F7, F8 and F9, XE, XP, XS, XU
Co-Surgeon/Team Surgeon	50, 62, 66, 80, 81, 82, AS
Discontinued Procedure	53
Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency	KH, KI, KJ, KM, KN, KR, KX, LT, MS, NR, NU, RR, RT, UE
Global Days	24, 25, 57, 58, 78, 79
Increased Procedural Services	22, 63
Injection and Infusion Services	25
Intensity Modulated Radiation Therapy	59, XU
Laboratory Services	59, 76, 77, 90, 91, 92, XE, XP, XS, XU
Maximum Frequency Per Day	50, 59, 76, 91, E1, E2, E3, E4, LC, LD, LM, LT, RC, RI, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, XE, XS, XU
Modifier SU	SU
MPPR Diagnostic Imaging	26, 59, 76, TC, XE
Multiple Procedure Payment Reduction	26, 50, 51, 53, 62, 66, 78, 80, 81, 82, AS, TC
Obstetrical	22, 24, 25, 26, 59, 76, 77
Once in a Lifetime Procedures	53, 55, 56, 58
One or More Sessions	50, 52, 53, 54, 55, 56, 79, LT, RT
Physical Medicine & Rehabilitation: PT, OT and Evaluation & Management, Speech Therapy, Maximum Combined Frequency Per Day, Multiple Therapy Procedure Reduction	GN, GO, GP
Preventive Medicine and Screening	25
Procedure to Modifier	Refer to the policy for further detail
Professional/Technical Component	26, 59, 76, 77, 91, E1, E2, E3, E4, LC, LD, LM, LT, RC, RI, RT, TC, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, FA, F1, F2, F3, F4, F5, F6,

	F7, F8, F9, XE, XP, XS, XU
Prolonged Services	25
Rebundling	25, 50, 57, 58, 59, 78, 79, 91, E1, E2, E3, E4, LC, LD, LM, LT, RC, RI, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, XE, XP, XS, XU
Reduced Services	52
Robotic Assisted Surgery	22
Same Day Same Service	25
Services and Modifiers Not Reimbursable to Healthcare Professionals	27, 73, 74, PO, H9, HU, HV, HW, HX, HY, HZ, QJ, SE, SL, TR
Split Surgical Package	54, 55, 56
Supply	KM, KN, NR, NU, UE
Telemedicine	95, G0, GQ, GT
Time Span Codes	52, 59, 76
Wrong Surgical or Other Invasive Procedures	PA, PB, PC

Questions and Answers

1	**Q:** How are claims reimbursed for an Ambulatory Surgical Center when submitted on a 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form with an SG modifier? **A:** Services reported on a CMS 1500 form with an SG modifier are not treated as professional claims. The SG modifier indicates facility services and the claim is treated as a facility claim and is not subject to UnitedHealthcare's reimbursement policies.

Resources

American Medical Association, *Coding with Modifiers*

American Medical Association, *Current Procedural Terminology (*CPT®) *Professional Edition* and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

History

8/30/2019	Policy Version Change Updates to Modifier Reference Tables and Reimbursement Policies section Updates to Resources section

2/10/2019	Policy Version Change Title section: Removed Annual Approval information & moved policy # to the header Policy Verbiage Change: Added modifiers 95 and G0 in the Telemedicine Policy History Section: Entries prior to 1/1/2017 archived
11/14/2018 – 2/9/2019	Annual Policy Approval Date and Version Change Added 'Professional' to the policy title; removed reference to Community and State and Medicare and Retirement in the Application section.
1/1/2018 – 11/13/2018	Annual Policy Version Change Policy Verbiage Change: Removed modifier CP from Services and Modifiers Not Reimbursable to Healthcare Professionals Policy History Section: Entries prior to 1/1/2016 archived
11/8/2017 – 12/31/2017	Policy Approval Date Change Policy Logo, Preamble and Footer have been updated Policy Verbiage Change: Added Intensity Modulated Radiation Therapy Policy; changed Radiology Multiple Imaging Reduction to MPPR Diagnostic Imaging Policy; annual maintenance of modifiers in reimbursement policies
1/1/2017 – 11/7/2017	Annual Policy Version Change Policy Verbiage Change: Added reference to modifiers 27, 73, 74, PO, H9, HU, HV, HW, HX, HY, HZ, QJ, SE, SL, TR in Services and Modifiers Not Reimbursable to Healthcare Professionals History Section: Entries prior to 1/1/2015 archived