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

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<tr>
<th>Modifier</th>
<th>Description</th>
<th>Industry Standards for usage according to AMA publications</th>
<th>Refer to Reimbursement Policy</th>
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</thead>
<tbody>
<tr>
<td>22</td>
<td>Increased Procedural Services</td>
<td>This modifier should not be appended to an E/M service.</td>
<td>Anesthesia, Increased Procedural Services, Obstetrical, Robotic Assisted Surgery</td>
</tr>
<tr>
<td>23</td>
<td>Unusual Anesthesia</td>
<td>Anesthesia</td>
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<td>24</td>
<td>Unrelated Evaluation and Management Service by the Same Physician or Other</td>
<td>This modifier is only used with E/M services in the CPT</td>
<td>CCI Editing, Global Days, Obstetrical</td>
</tr>
<tr>
<td></td>
<td>Qualified Health Care Professional During a Postoperative Period</td>
<td>codebook. It is not used in any other section of the CPT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>codebook.</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Significant, Separately Identifiable Evaluation and Management Service by</td>
<td>Modifier 25 should be used with E/M codes only and not</td>
<td>CCI Editing, Global Days, Injection and Infusion Services, Obstetrical, Preventive Medicine</td>
</tr>
<tr>
<td></td>
<td>the Same Physician or Other Qualified Health Care Professional on the Same</td>
<td>appended to the surgical procedure code(s).</td>
<td>&amp; Screening, Prolonged Services, Rebundling, Same Day Same Service</td>
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<tr>
<td></td>
<td>Day of the Procedure or Other Service</td>
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<td>26</td>
<td>Professional Component</td>
<td>MPPR Diagnostic Imaging, Multiple Procedure Reduction,</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Obstetrical, Professional/Technical Component</td>
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<td>27</td>
<td>Multiple Outpatient Hospital E/M Encounters on the Same Date</td>
<td>This modifier is approved for ambulatory surgery center (ASC)</td>
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<td>hospital outpatient use</td>
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<td>47</td>
<td>Anesthesia by Surgeon</td>
<td>Modifier 47 would not be used as a modifier for the</td>
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<td></td>
<td></td>
<td>anesthesia procedures.</td>
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<tr>
<td>50</td>
<td>Bilateral Procedure</td>
<td>Bilateral Procedures, Co-Surgeon/Team Surgeon, Maximum</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frequency per Day, Multiple Procedure Reduction, One or</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>More Sessions, Rebundling</td>
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<tr>
<td>51</td>
<td>Multiple Procedures</td>
<td>Multiple Procedure Reduction</td>
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<td>52</td>
<td>Reduced Services</td>
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<td>Discontinued Procedure</td>
<td>Discontinued Procedure, Multiple Procedure Reduction, Once in a Lifetime Procedures, One or More Sessions</td>
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<td>Surgical Care Only</td>
<td>One or More Sessions, Split Surgical Package</td>
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<tr>
<td>55</td>
<td>Postoperative Management Only</td>
<td>Once in a Lifetime Procedures, One or More Sessions, Split Surgical Package</td>
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<tr>
<td>56</td>
<td>Preoperative Management Only</td>
<td>Once in a Lifetime Procedures, One or More Sessions, Split Surgical Package</td>
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<td>57</td>
<td>Decision for Surgery</td>
<td>Modifier 57 is used only with an E/M service. CCI Editing, Global Days, Rebundling</td>
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<td>58</td>
<td>Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period</td>
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<td>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</td>
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<td>62</td>
<td>Two Surgeons</td>
<td>Co-Surgeon/Team Surgeon, Multiple Procedure Reduction</td>
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<td>63</td>
<td>Procedure Performed on Infants less than 4kg</td>
<td>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</td>
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<tr>
<td>66</td>
<td>Surgical Team</td>
<td>Co-Surgeon/Team Surgeon, Multiple Procedure Reduction</td>
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<td>73</td>
<td>Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia</td>
<td>This modifier is approved for ambulatory surgery center (ASC) hospital outpatient use Services and Modifiers Not Reimbursable to Healthcare Professionals</td>
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<tr>
<td>74</td>
<td>Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia</td>
<td>This modifier is approved for ambulatory surgery center (ASC) hospital outpatient use Services and Modifiers Not Reimbursable to Healthcare Professionals</td>
<td></td>
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<tr>
<td>Code</td>
<td>Description</td>
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<td>Codes</td>
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<td>76</td>
<td>Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional</td>
<td>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.</td>
<td>Anesthesia, Laboratory Services, Maximum Frequency per Day, MPPR Diagnostic Imaging, Obstetrical, Professional/Technical Component, Time Span Codes</td>
</tr>
<tr>
<td>77</td>
<td>Repeat Procedure by Another Physician or Other Qualified Health Care Professional</td>
<td>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.</td>
<td>Anesthesia, Laboratory Services, Obstetrical, Professional/Technical Component</td>
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<tr>
<td>78</td>
<td>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</td>
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<td>Anesthesia, CCI Editing, Global Days, Multiple Procedure Reduction, Rebundling</td>
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<tr>
<td>79</td>
<td>Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period</td>
<td></td>
<td>Anesthesia, CCI Editing, Global Days, One or More Sessions, Rebundling</td>
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<tr>
<td>80</td>
<td>Assistant Surgeon</td>
<td></td>
<td>Assistant Surgeon, Co-Surgeon/Team Surgeon, Multiple Procedure Reduction</td>
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<tr>
<td>81</td>
<td>Minimum Assistant Surgeon</td>
<td></td>
<td>Assistant Surgeon, Co-Surgeon/Team Surgeon, Multiple Procedure Reduction</td>
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<tr>
<td>82</td>
<td>Assistant Surgeon (when qualified resident surgeon not available)</td>
<td></td>
<td>Assistant Surgeon, Co-Surgeon/Team Surgeon, Multiple Procedure Reduction</td>
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<td>90</td>
<td>Reference (Outside) Laboratory</td>
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<tr>
<td>91</td>
<td>Repeat Clinical Diagnostic Laboratory Test</td>
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<td>CCI Editing, Laboratory Services, Maximum Frequency per Day, Professional/Technical Component, Rebundling</td>
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<td>92</td>
<td>Alternative Laboratory Platform Testing</td>
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<td>Laboratory Services</td>
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<tr>
<td>95</td>
<td>Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System</td>
<td></td>
<td>Telemedicine</td>
</tr>
<tr>
<td>AA</td>
<td>Anesthesia services performed personally by anesthesiologist</td>
<td></td>
<td>Anesthesia</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>CPT Code</td>
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</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>AD</td>
<td>Medical supervision by a physician: more than 4 concurrent anesthesia procedures</td>
<td>Anesthesia</td>
<td></td>
</tr>
<tr>
<td>AS</td>
<td>Physician Assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery</td>
<td>Assistant Surgeon, Co-Surgeon/Team Surgeon, Multiple Procedure Reduction</td>
<td></td>
</tr>
<tr>
<td>E1- E4</td>
<td>Anatomic modifiers which are associated with the eyelid</td>
<td>CCI Editing, Maximum Frequency per Day, Professional/Technical Component, Rebundling</td>
<td></td>
</tr>
<tr>
<td>FA, F1-F9</td>
<td>Anatomic modifiers which are associated with the fingers</td>
<td>CCI Editing, Maximum Frequency per Day, Professional/Technical Component, Rebundling</td>
<td></td>
</tr>
<tr>
<td>G0</td>
<td>Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke</td>
<td>Telemedicine</td>
<td></td>
</tr>
<tr>
<td>G8</td>
<td>Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure</td>
<td>Anesthesia</td>
<td></td>
</tr>
<tr>
<td>G9</td>
<td>Monitored anesthesia care for patient who has history of severe cardiopulmonary condition</td>
<td>Anesthesia</td>
<td></td>
</tr>
<tr>
<td>GC</td>
<td>This service has been performed in part by a resident under the direction of a teaching physician</td>
<td>Anesthesia</td>
<td></td>
</tr>
<tr>
<td>GN</td>
<td>Service delivered under an outpatient speech language pathology plan of care</td>
<td>Physical Medicine &amp; Rehabilitation: Speech Therapy, Maximum Combined Frequency Per Day, Multiple Therapy Procedure Reduction</td>
<td></td>
</tr>
<tr>
<td>GO</td>
<td>Service delivered under an outpatient occupational therapy plan of care</td>
<td>Physical Medicine &amp; Rehabilitation: PT, OT and Evaluation &amp; Management, Maximum Combined Frequency Per Day, Multiple Therapy Procedure Reduction</td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td>Service delivered under an outpatient physical therapy plan of care</td>
<td>Physical Medicine &amp; Rehabilitation: PT, OT and Evaluation &amp; Management, Maximum Combined Frequency Per Day, Multiple Therapy Procedure Reduction</td>
<td></td>
</tr>
<tr>
<td>GQ</td>
<td>Via asynchronous telecommunications system</td>
<td>Telemedicine</td>
<td></td>
</tr>
<tr>
<td>Modifier(s)</td>
<td>Description</td>
<td>Reimbursement Notes</td>
<td></td>
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<td>------------</td>
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<td></td>
</tr>
<tr>
<td>GT</td>
<td>Via interactive audio and video telecommunications systems</td>
<td>Telemedicine</td>
<td></td>
</tr>
<tr>
<td>H9, HU, HV, HW, HX, HY, HZ, QJ, SE, SL, TR</td>
<td>Modifiers which represent services that are funded by a county, state or federal agency</td>
<td>Services and Modifiers Not Reimbursable to Healthcare Professionals</td>
<td></td>
</tr>
<tr>
<td>KH, KI, KJ, KM, KN, KR, KX, MS, NR, NU, RR, UE</td>
<td>Modifiers associated with Durable Medical Equipment and Orthotic/Prosthetic Devices</td>
<td>Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency, Supply</td>
<td></td>
</tr>
<tr>
<td>LC, LD, LM, RC, RI</td>
<td>Anatomic modifiers which are associated with the coronary arteries</td>
<td>CCI Editing, Maximum Frequency per Day, Professional/Technical Component, Rebundling</td>
<td></td>
</tr>
<tr>
<td>LT</td>
<td>Left side (used to identify procedures performed on the left side of the body)</td>
<td>Bilateral Procedures, CCI Editing, Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency Per Day, Maximum Frequency Per Day, One or More Sessions, Professional/Technical Component, Rebundling</td>
<td></td>
</tr>
<tr>
<td>P1</td>
<td>A normal healthy patient</td>
<td>Anesthesia</td>
<td></td>
</tr>
<tr>
<td>P2</td>
<td>A patient with mild systemic disease</td>
<td>Anesthesia</td>
<td></td>
</tr>
<tr>
<td>P3</td>
<td>A patient with severe systemic disease</td>
<td>Anesthesia</td>
<td></td>
</tr>
<tr>
<td>P4</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
<td>Anesthesia</td>
<td></td>
</tr>
<tr>
<td>P5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
<td>Anesthesia</td>
<td></td>
</tr>
</tbody>
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All anesthesia services are reported by use of the anesthesia five-digit procedure code (00100-01999) with the appropriate physical status modifier appended.

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<th>Code</th>
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<th>Reimbursement Notes</th>
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<tbody>
<tr>
<td>P6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
<td>All anesthesia services are reported by use of the anesthesia five-digit procedure code (00100-01999) with the appropriate physical status modifier appended.</td>
</tr>
<tr>
<td>PA</td>
<td>Surgical or other invasive procedure on wrong body part</td>
<td>Wrong Surgical or Other Invasive Procedures</td>
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<tr>
<td>PB</td>
<td>Surgical or other invasive procedure on wrong patient</td>
<td>Wrong Surgical or Other Invasive Procedures</td>
</tr>
<tr>
<td>PC</td>
<td>Wrong surgery or other invasive procedure on patient</td>
<td>Wrong Surgical or Other Invasive Procedures</td>
</tr>
<tr>
<td>PO</td>
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<td>Services and Modifiers Not Reimbursable to Healthcare Professionals</td>
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<tr>
<td>QK</td>
<td>Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals</td>
<td>Anesthesia</td>
</tr>
<tr>
<td>QS</td>
<td>Monitored anesthesia care service</td>
<td>Anesthesia</td>
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<tr>
<td>QX</td>
<td>CRNA service: with medical direction by a physician</td>
<td>Anesthesia</td>
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<tr>
<td>QY</td>
<td>Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist</td>
<td>Anesthesia</td>
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<tr>
<td>QZ</td>
<td>CRNA service: without medical direction by a physician</td>
<td>Anesthesia</td>
</tr>
<tr>
<td>RT</td>
<td>Right side (used to identify procedures performed on the right side of the body)</td>
<td>Bilateral Procedures, CCI Editing, Durable Medical Equipment, Orthotics and Prosthetics Multiple Procedure Reduction, Professional/Technical Component, Rebandling</td>
</tr>
<tr>
<td>SG</td>
<td>Ambulatory surgical center (ASC) facility service</td>
<td>Not applicable – refer to the Questions and Answers section of this policy</td>
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<tr>
<td>SU</td>
<td>Procedure performed in physician’s office (to denote use of facility and equipment)</td>
<td>Modifier SU</td>
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<td>TA, T1 - T9</td>
<td>Anatomic modifiers which are associated with the toes</td>
<td>CCI Editing, Maximum Frequency per Day, Professional/Technical Component, Rebandling</td>
</tr>
<tr>
<td>TC</td>
<td>Technical Component</td>
<td>MPPR Diagnostic Imaging, Multiple Procedure Reduction, Professional/Technical Component</td>
</tr>
<tr>
<td>Modifier</td>
<td>Description</td>
<td>HCPCS modifiers for selective identification of subsets of Distinct Procedural Services [-59 modifier]</td>
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<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>XE</td>
<td>Separate encounter, a service that is distinct because it occurred during a separate encounter</td>
<td>Anesthesia, CCI Editing, Laboratory Services, Maximum Frequency per Day, MPPR Diagnostic Imaging, Professional/Technical Component, Rebundling</td>
</tr>
<tr>
<td>XP</td>
<td>Separate practitioner, a service that is distinct because it was performed by a different practitioner</td>
<td>CCI Editing, Laboratory Services, Professional/Technical Component, Rebundling</td>
</tr>
<tr>
<td>XS</td>
<td>Separate structure, a service that is distinct because it was performed on a separate organ/structure</td>
<td>Bilateral Procedures, CCI Editing, Laboratory Services, Maximum Frequency per Day, Professional/Technical Component, Rebundling</td>
</tr>
<tr>
<td>XU</td>
<td>Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service</td>
<td>Anesthesia, CCI Editing, Intensity Modulated Radiation Therapy, Laboratory Services, Maximum Frequency per Day, Professional/Technical Component, Rebundling</td>
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<th>Reimbursement Policy</th>
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<td>Bilateral Procedures</td>
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<tr>
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<td>Laboratory Services</td>
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<td>Maximum Frequency Per Day</td>
<td>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 and F9, XE, XS, XU</td>
</tr>
<tr>
<td>Modifier SU</td>
<td>SU</td>
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</tbody>
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**Questions and Answers**

**1.** 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*

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<th>Date Range</th>
<th>Description</th>
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</table>
| 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 |