# MODIFIER REFERENCE POLICY

**Policy Number**: ADMINISTRATIVE 026.20 T0 **Effective Date**: November 1, 2017

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**Related Policies**

- Refer to the Reimbursement Guidelines section of the policy

## INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

## APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

## APPLICATION

This reimbursement policy applies to services reported using the UB-04 claim form, the 1500 Health Insurance Claim Form (a/k/a CMS-1500), or their electronic equivalents or their successor forms. This policy applies to all network and non-network providers, including hospitals, ambulatory surgical centers, 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.

## 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.

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

## REIMBURSEMENT GUIDELINES

| Modifier | Description | Industry Standards for Usage According to AMA Publication Coding with Modifiers | Refer to Reimbursement Policy/ Informational Purposes Only |
|---|---|---|---|
| 22 | Increased Procedural Services | This modifier should not be appended to an E/M service. | Refer to policies:<br>• *Increased Procedural Services*<br>• *Obstetrical Policy*<br>• *Robotic Assisted Surgery* |
| 23 | Unusual Anesthesia | | Informational Purposes Only |
| 24 | Unrelated Evaluation & 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. | Refer to policies:<br>• *Global Days*<br>• *Obstetrical Policy* |
| 25 | Significant, Separately Identifiable Evaluation & 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). | Refer to policies:<br>• *Global Days*<br>• *Injection and Infusion Services*<br>• *Obstetrical Policy*<br>• *Pediatric and Neonatal Critical and Intensive Care Services*<br>• *Preventive Medicine and Screening*<br>• *Prolonged Services*<br>• *Same Day/Same Service* |
| 26 | Professional Component | Services that have been deemed eligible as a professional component will be reimbursed at a reduced rate and will be identified with modifier -26.<br><br>*__Note__: Some providers (physicians and facilities) may be reimbursed both the technical (-TC) and professional (-26) component. This is referred to as a global reimbursement. In order to be eligible for this global reimbursement, the provider must be credentialed as a full service provider or have a contract that states both components may be reimbursed to the provider. | Refer to policies:<br>• *Multiple Procedures*<br>• *Obstetrical Policy* |
| 27 | Multiple Outpatient Hospital E/M Encounters on the Same Date | This modifier is approved for ambulatory surgery center (ASC) hospital outpatient use | Refer to policy:<br>• *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. | Informational Purposes Only |
| 50 | Bilateral Procedure | | Refer to policies:<br>• *Bilateral Procedures*<br>• *Co-Surgeon/Team Surgeon*<br>• *Maximum Frequency Per Day*<br>• *Multiple Procedures*<br>• *One or More Sessions* |
| 51 | Multiple Procedure | | Refer to policy:<br>• *Multiple Procedures* |

| Modifier | Description | Industry Standards for Usage According to AMA Publication Coding with Modifiers | Refer to Reimbursement Policy/ Informational Purposes Only |
|---|---|---|---|
| 52 | Reduced Services | | Refer to policies:<br>• *Bilateral Procedures*<br>• *Discontinued Procedure*<br>• *One or More Sessions*<br>• *Reduced Services*<br>• *Time Span Codes* |
| 53 | Discontinued Services | | Refer to policies:<br>• *Discontinued Procedure*<br>• *Multiple Procedures*<br>• *Once in a Lifetime Procedures*<br>• *One or More Sessions* |
| 54 | Surgical Care Only | | Refer to policies:<br>• *One or More Sessions*<br>• *Split Surgical Package* |
| 55 | Postoperative Management Only | | Refer to policies:<br>• *One or More Sessions*<br>• *Once in a Lifetime Procedures*<br>• *Split Surgical Package* |
| 56 | Preoperative Management Only | | Refer to policies:<br>• *Split Surgical Package*<br>• *One or More Sessions*<br>• *Once in a Lifetime Procedures* |
| 57 | Decision for Surgery | Modifier 57 is used only with an E/M service. | Refer to policy:<br>• *Global Days* |
| 58 | Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period | | Refer to policies:<br>• *Global Days*<br>• *Once in a Lifetime Procedures* |
| 59 | Distinct Procedural Service | This modifier should not be appended to an E/M service. | Refer to policies:<br>• *Bilateral Procedures*<br>• *Maximum Frequency Per Day*<br>• *Obstetrical Policy*<br>• *Time Span Codes* |
| 62 | Two Surgeons | | Refer to policies:<br>• *Co-Surgeon/Team Surgeon*<br>• *Multiple Procedures* |
| 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. | Refer to policy:<br>• *Increased Procedural Services* |
| 66 | Surgical Team | | Refer to policies:<br>• *Co-Surgeon/Team Surgeon*<br>• *Multiple Procedures* |
| 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 | Refer to policy:<br>• *Services and Modifiers Not Reimbursable to Healthcare Professionals* |

| Modifier | Description | Industry Standards for Usage According to AMA Publication Coding with Modifiers | Refer to Reimbursement Policy/ Informational Purposes Only |
|---|---|---|---|
| 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 | Refer to policy:<br>• *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.<br>For repeat laboratory tests performed on the same day, use modifier 91. For multiple specimens/sites use modifier 59 | Refer to policies:<br>• *Maximum Frequency Per Day*<br>• *Obstetrical Policy*<br>• *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.<br>For repeat laboratory tests performed on the same day, use modifier 91. For multiple specimens/sites use modifier 59. | Refer to policy:<br>• *Obstetrical Policy* |
| 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 | | Refer to policies:<br>• *Global Days*<br>• *Multiple Procedures* |
| 79 | Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period | | Refer to policy:<br>• *Global Days* |
| 80 | Assistant Surgeon | | Refer to policies:<br>• *Assistant Surgeon*<br>• *Co-Surgeon/Team Surgeon*<br>• *Multiple Procedures* |
| 81 | Minimum Assistant Surgeon | | Refer to policies:<br>• *Assistant Surgeon*<br>• *Co-Surgeon/Team Surgeon*<br>• *Multiple Procedures* |
| 82 | Assistant Surgeon (when qualified resident surgeon not available) | | Refer to policies:<br>• *Assistant Surgeon*<br>• *Co-Surgeon/Team Surgeon*<br>• *Multiple Procedures* |
| 90 | Reference (Outside) Laboratory | | Informational Purposes Only |
| 91 | Repeat Clinical Diagnostic Laboratory Test | | Refer to policy:<br>• *Maximum Frequency Per Day* |
| 92 | Alternative Laboratory Platform Testing | | Informational Purposes Only |
| AA | Anesthesia services performed personally by an anesthesiologists | | Informational Purposes Only |

| Modifier | Description | Industry Standards for Usage According to AMA Publication Coding with Modifiers | Refer to Reimbursement Policy/ Informational Purposes Only |
|---|---|---|---|
| AD | Medical supervision by a physician: more than four concurrent anesthesia procedures. | | Informational Purposes Only |
| AS | Physician Assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery. | | Refer to policies:<br>• *Assistant Surgeon*<br>• *Co-Surgeon/Team Surgeon*<br>• *Multiple Procedures*<br>• *Physician Extenders* |
| CP | Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification (c-APC) procedure, but reported on a different claim | | Refer to policy:<br>• *Services and Modifiers Not Reimbursable to Healthcare Professionals* |
| E1-E4 | Anatomic modifiers which are associated with the eyelid | | Refer to policy:<br>• *Maximum Frequency Per Day* |
| FA, F1-F9 | Anatomic modifiers which are associated with the fingers | | Refer to policies:<br>• *Bilateral Procedures*<br>• *Maximum Frequency Per Day* |
| G8 | Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure | | Informational Purposes Only |
| G9 | Monitored anesthesia care for patient who has history of severe cardiopulmonary condition | | Informational Purposes Only |
| GC | This service has been performed in part by a resident under the direction of a teaching physician | | Informational Purposes Only |
| GN | Service delivered under an outpatient speech-language pathology plan of care | | Informational Purposes Only |
| GO | Service delivered under an outpatient occupational therapy plan of care | | Informational Purposes Only |
| GP | Service delivered under an outpatient physical therapy plan of care. | | Informational Purposes Only |
| GQ | Via asynchronous telecommunications system | | Refer to policy:<br>• *Telemedicine* |
| GT | Via interactive audio and video telecommunications systems | | Refer to policy:<br>• *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 | | Refer to policy:<br>• *Services and Modifiers Not Reimbursable to Healthcare Professionals* |

| Modifier | Description | Industry Standards for Usage According to AMA Publication Coding with Modifiers | Refer to Reimbursement Policy/ Informational Purposes Only |
|---|---|---|---|
| KH, KI, KJ, KM, KN, KR, MS, NR, NU, RR, TW, UE | Modifiers associated with Durable Medical Equipment and Orthotic/Prosthetic Devices | | Refer to policies:<br>• *Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency*<br>• *Supply Policy* |
| LC, LD, LM, RC, RI | Anatomic modifiers which are associated with the coronary arteries | | Refer to policy:<br>• *Maximum Frequency Per Day* |
| LT | Left side (used to identify procedures performed on the left side of the body) | | Refer to policies:<br>• *Bilateral Procedures*<br>• *Maximum Frequency Per Day*<br>• *Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency*<br>• *One or More Sessions* |
| 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. | Informational Purposes Only |
| 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. | Informational Purposes Only |
| 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. | Informational Purposes Only |
| 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. | Informational Purposes Only |
| 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. | Informational Purposes Only |
| 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. | Informational Purposes Only |
| PA | Surgical or other invasive procedure on wrong body part | | Refer to policy:<br>• *Wrong Surgical or Other Invasive Procedures* |
| PB | Surgical or other invasive procedure on wrong patient | | Refer to policy:<br>• *Wrong Surgical or Other Invasive Procedures* |
| PC | Wrong surgery or other invasive procedure on patient | | Refer to policy:<br>• *Wrong Surgical or Other Invasive Procedures* |

| Modifier | Description | Industry Standards for Usage According to AMA Publication Coding with Modifiers | Refer to Reimbursement Policy/ Informational Purposes Only |
|---|---|---|---|
| PO | Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments | | Refer to policy:<br>• *Services and Modifiers Not Reimbursable to Healthcare Professionals* |
| QK | Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals. | | Informational Purposes Only |
| QS | Monitored anesthesia care service | | Informational Purposes Only |
| QX | CRNA service; with medical direction by a physician | | Refer to policy:<br>• *Physician Extenders* |
| QY | Medical direction of one Certified Registered Nurse Anesthetist (CRNA) by an anesthesiologist. | | Refer to policy:<br>• *Physician Extenders* |
| QZ | CRNA service; without medical direction by a physician. | | Informational Purposes Only |
| RT | Right side (used to identify procedures performed on the right side of the body) | | Refer to policies:<br>• *Bilateral Procedures*<br>• *Maximum Frequency Per Day*<br>• *Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency*<br>• *One or More Sessions* |
| SG | Ambulatory surgical center (ASC) facility service | | Informational Purposes Only |
| SU | Procedure performed in physician's office (to denote use of facility and equipment) | | Refer to policy:<br>• *Modifier SU* |
| TA, T1-T9 | Anatomic modifiers which are associated with the toes | | Refer to policies:<br>• *Bilateral Procedures*<br>• *Maximum Frequency Per Day* |
| TC | Technical Component | Services that have been deemed eligible as a technical component will be reimbursed at a reduced rate and will be identified with modifier -TC.<br>*__Note__: Some providers (physicians and facilities) may be reimbursed both the technical (-TC) and professional (-26) component. This is referred to as a global reimbursement. In order to be eligible for this global reimbursement, the provider must be credentialed as a full service provider or have a contract that states both components may be reimbursed to the provider. | Refer to policy:<br>• *Multiple Procedures* |
| 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] | Refer to policies:<br>• *Maximum Frequency Per Day*<br>• *Obstetrical Policy* |

| Modifier | Description | Industry Standards for Usage According to AMA Publication Coding with Modifiers | Refer to Reimbursement Policy/ Informational Purposes Only |
|---|---|---|---|
| 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] | Informational Purposes Only |
| 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] | Refer to policies:<br>• *Bilateral Procedures*<br>• *Maximum Frequency Per Day*<br>• *Obstetrical Policy* |
| 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] | Refer to policies:<br>• *Maximum Frequency Per Day*<br>• *Obstetrical Policy* |

| Reimbursement Policy | Modifier |
|---|---|
| *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 |
| *Co-Surgeon/Team Surgeon* | 50, 62, 66, 80, 81, 82, AS |
| *Discontinued Procedure* | 52, 53 |
| *Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency* | KH, KI, KJ, KM, KN, KR, LT, MS, NR, NU, RR, RT, TW, UE |
| *Global Days* | 24, 25, 57, 58, 78, 79 |
| *Increased Procedural Services* | 22, 63 |
| *Injection and Infusion Services* | 25 |
| *Maximum Frequency Per Day* | 50, 59, 76, 91, E1, E2, E3, E4, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, LC, LD, LM, LT, RC, RI, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, XE, XS, XU |
| *Modifier SU* | SU |
| *Multiple Procedures* | 26, 50, 51, 62, 66, 78, 80, 81, 82, AS, TC |
| *Obstetrical Policy* | 22, 24, 25, 26, 59, 76, 77, XE, XS, XU |
| *Once in a Lifetime Procedures* | 53, 55, 56, 58 |
| *One or More Sessions* | 50, 52, 53, 54, 55, 56, LT, RT |
| *Pediatric and Neonatal Critical and Intensive Care Services* | 25 |
| *Physician Extenders* | AS, QX, QY |
| *Preventive Medicine and Screening* | 25 |
| *Prolonged Services* | 25 |
| *Reduced Services* | 52 |
| *Robotic Assisted Surgery* | 22 |
| *Same Day/Same Service* | 25 |
| *Services and Modifiers Not Reimbursable to Healthcare Professionals* | 27, 73, 74, CP, H9, HU, HV, HW, HX, HY, HZ, PO, QJ, SE, SL, TR |
| *Split Surgical Package* | 54, 55, 56 |
| *Supply Policy* | KM, KN, NR, NU, UE |
| *Telemedicine* | GQ, GT |
| *Time Span Codes* | 52, 59, 76 |
| *Wrong Surgical or Other Invasive Procedures* | PA, PB, PC |

## REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Reimbursement Policy Oversight Committee. [*2017R0111A*]

American Medical Association, *Coding with Modifiers*.

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

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

## POLICY HISTORY/REVISION INFORMATION

| Date | Action/Description |
|---|---|
| 10/01/2018 | • Reformatted references to related Reimbursement Policies |
| 11/01/2017 | • Updated reference guidance for:<br>○ Modifiers 27, 73, and 74; added description, industry standards for usage, and reference link to related policy titled *Services and Modifiers Not Reimbursable to Healthcare Professionals*<br>○ Modifier G9; updated description<br>○ Modifiers H9, HU, HV, HW, HX, HY, HZ, PO, QJ, SE, SL, and TR; added description and reference link to related policy titled *Services and Modifiers Not Reimbursable to Healthcare Professionals*<br>• Updated supporting information to reflect the most current references<br>• Archived previous policy version ADMINISTRATIVE 026.19 T0 |