Kansas City

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Modifiers

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Descriptions

This policy will address Blue KC coding and coverage of modifiers. These guidelines are not intended to provide billing or coding advice but to serve as a reference for facilities and providers.

Definitions

Modifiers indicate that a service was altered in some way from the stated descriptor without changing the definition. The American Medical Association (AMA) modifiers are two-digit alpha/numeric codes listed after a procedure or supply code and separated from the code by a hyphen (e.g., 92506-22).

Policy Statement

Below, are modifiers most often received by Blue KC with the description of the modifier. Appropriateness of modifiers is based on clinical edits, CMS edits and the American Medical Association guidelines. Documentation may be required to confirm the validity of the billed modifier. Clinical editing (sub setting, redundant, etc.) may still apply.

MODIFIER	MODIFIER DESCRIPTION	PRICING/FUNCTIONALITY
22	Unusual Procedural Services	▪ Reimbursement is 125% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ When the service(s) provided is greater than that usually required for the listed procedure, it may be

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		▪ Identified by adding modifier -22 to the usual procedure number. A report may also be appropriate. ▪ It is not appropriate for CPT codes with the term "simple" as part of the code description. Rather, it is used to indicate that a procedure was complicated, complex, difficult, or took significantly more time than usually required by the physician or practitioner to complete the procedure. Documentation must be kept in the medical record when this modifier is used. ▪ This is because it is often used when complications are encountered during surgical procedures, medical necessity is substantiated by additional diagnostic codes that identify the complication. These diagnostic codes should reflect the operative condition and the complication(s) encountered during the surgery. ▪ Will not be reimbursed for anesthesia services billing "field avoidance."
23	Unusual Anesthesia	▪ Reimbursement is 100% of the 5-digit allowable. ▪ Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. ▪ Should be used on basic service procedure codes (00100-01999). This modifier is used when

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		▪ general anesthesia is administered in situations in which local anesthesia might have been required, but would not be sufficient under the circumstances. Documentation explaining the need for general anesthesia may be required. ▪ It should not be used with surgical codes or for local anesthesia.
24	Unrelated Evaluation and Management Service by the Same Physician during a Postoperative Period	▪ Reimbursement is 100% of the 5-digit allowable. ▪ It allows the physician to report a service performed during a postoperative period for reason(s) unrelated to the original procedure. The postoperative period for a major surgery (defined as a surgery with a 90-day follow-up period) includes all routine care of the patient for surgery-related services. It should be billed with an E/M code. Do not use this modifier with a CPT surgical code. Assign the proper E/M code for service rendered. ▪ Subsequent hospital care (99231-99233) and critical care services (99291-99292) by the surgeon during the same hospitalization as the surgery may be considered related to the surgery. Separate payment for such a visit is not allowed even when billed with the -24 modifier unless one of the following exceptions applies: ○ Immunotherapy management furnished by the transplant surgeon.

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		○ Critical care services unrelated to the surgery for a seriously injured or burned patient considered critically ill or injured and requiring constant physician attendance. ○ Documentation attached to the claim demonstrates that the care being provided during the inpatient visits following surgery is not related to the surgery.
25	Significant, Separately Identifiable Evaluation and Management service by the Same Physician on the Same Day of the Procedure or Other Service	▪ Reimbursement is 100% of the 5-digit allowable. ▪ It indicates that on a day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. Assign the proper E/M code as appropriate for service rendered.

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		• Documentation of unusual circumstances may be submitted with the claim. ▪ The CPT codes for procedures **DO** include the evaluation services necessary prior to the performance of the procedure (eg, assessing the site/condition of the problem area, explaining the procedure, obtaining informed consent including discussing risks, alternatives, benefits, etc.). ▪ Blue KC may conduct post-payment reviews of the use of the modifier to determine whether the use of the modifier was justified. If office records indicate that the use of the -25 was not justified according to the CPT definition, a refund of the payment for that E/M code may be requested. ▪ When an E/M Service is provided on the same day as a preventive care service, the modifier may be used to indicate a separately identifiable E/M was provided. Payment for the E/M may require post-service review to determine whether the modifier was appropriately billed and that the level of E/M service is documented.

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		▪ CMS Guidelines state: "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported." ▪ This modifier may not be used to report an E/M Service that resulted in a decision to perform major surgery (surgery with a post-op period of 90 days). See modifier -57.
26	Professional Component	▪ Reimbursement varies. ▪ Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service should be identified by adding the modifier -26 to the usual procedure code. It is used in those instances in which a physician is providing the interpretation of the diagnostic test/study performed. The interpretation of the diagnostic test/study has to be separate, distinct, identifiable, written, and

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		signed. The written report must include findings, relevant clinical issues and, if appropriate comparative data. ▪ A review of the diagnostic procedure findings, without a written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for modifier use. The review of the findings, usually documented in the medical record or on a machine generated report as "fx-tibia" or "EKGWNL" does not suffice as a separately identifiable and, therefore, payable interpretation and report. ▪ It is not to be used for a reread of results of an interpretation initially provided by another physician. Without limitation to the above guidelines, this policy is intended to be consistent with Medicare reimbursement rules and it is Blue KC's policy to only reimburse Modifier -26 (professional component) for lab codes (80000 series codes) that are recognized by Medicare as eligible for payment.
32	Mandated Service	▪ Reimbursement is 100% of the 5-digit allowable. ▪ Services related to mandated consultation and/or related services (e.g., PRO, third party payer, governmental, legislative or regulatory requirement). This code should not be used when a

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		patient or family member requests a second opinion from another physician.
33	Preventative	▪ When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending modifier - 33, Preventive Service, to the service. For separately reported services specifically identified as preventive, the modifier should not be used. ▪ It is applicable for the identification of preventive services without cost-sharing in these four categories: ○ Services rated "A" or "B" by the US Preventive Services Task Force (USPSTF) as posted annually on the Agency for Healthcare Research and Quality's Web site. Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. ○ Preventive care and screenings for children as recommended by Bright Futures (American Academy of Pediatrics) and Newborn Testing (American College

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		of Medical Genetics) as supported by the Health Resources and Services Administration. ▪ Preventive care and screenings provided for women (not included in the Task Force recommendations) in the comprehensive guidelines supported by the Health Resources and Services Administration.
47	Anesthesia by Surgeon	▪ Regional or general anesthesia provided by the surgeon may be reported by adding the modifier -47 to the surgery code. (This does not include local anesthesia.) ▪ This modifier would not be used as a modifier for the anesthesia procedure codes (0 codes). If the same physician performs anesthesia and surgery, the anesthesia is considered inclusive with the surgery. No separate or additional benefit is available for the anesthesia, since the patient is not managed separately from an anesthesia standpoint. The -47 modifier added to the surgical CPT code indicates this scenario. ▪ Intravenous anesthesia or moderate sedation administered by a qualified medical person working under the direction of the physician for procedures appearing in Appendix G of the AMA's Current Procedure Terminology (CPT) book is

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		considered a component of the procedure itself. No separate or additional reimbursement will be allowed.(CPT codes 99143, 99144, and 99145)
50	Bilateral Procedures	▪ Reimbursement is 150% - 200% of the 5-digit allowable depending on Medicare guidelines. Multiple surgery guidelines may also apply. ▪ Unless otherwise identified in the listings, identical bilateral procedures that are performed at the same operative session should be identified by adding this to the appropriate five digit code. When billing bilateral procedures that are performed in conjunction with other multiple surgery procedures, the bilateral procedure should be submitted on one line with the modifier. ▪ The modifier should never be used with procedure codes identified by their terminology as "bilateral", e.g. 27395 (lengthening of hamstring tendon, multiple, bilateral) or procedures identified as "unilateral or bilateral", e.g., 52290 (cystourethroscopy, with meatotomy, unilateral or bilateral). ▪ When billing bilateral radiology procedures (code series 7XXXX), the LT and RT modifiers should be used in lieu of the -50 modifier for correct reimbursement.

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		▪ The fee allowance for a bilateral procedure (defined as an identical surgical procedure performed on both sides of the body during the same operative session) will be based on 150% of the unilateral allowance.
51	Multiple Procedures	▪ Reimbursement is 100% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ When multiple procedures, other than E/M services, are performed at the same session by the same physician or practitioner, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier -51 to the additional procedure or service code(s). This modifier should be not appended to designate 'add-on' codes. ▪ BCBSKC does not require nor recommend the use of the -51 modifier. The claims payment system recognizes multiple procedures without the use of the -51 modifier. Use of the -51 modifier does not alter clinical editing or subset arrangements. Please see modifier -59 for identification of distinct procedural services.

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52	Reduced Services	▪ Reimbursement is 75% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure code and the addition of the modifier '-52', signifying that the service is reduced. ▪ This provides a means of reporting reduced services without disturbing the identification of the basic service. ▪ It is appended when a service or procedure is partially reduced or eliminated at the physician’s discretion, i.e., started but discontinued. This modifier is not used to report the elective cancellation of a procedure before anesthesia induction and/or surgical preparation in the operating suite. ▪ This modifier would also be used to identify a procedure performed unilaterally which is defined by CPT as a bilateral procedure. The reduction in charge reflects the reduction or elimination of a portion of the service. ▪ The use of the –LT or –RT modifier is inappropriate coding when used to indicate an inherently bilateral procedure was performed unilaterally.

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53	Discontinued Procedure	▪ Reimbursement is 50% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. ▪ This modifier is not used to report the elective cancellation of a procedure prior to inducing anesthesia and/or surgical preparation in the operating suite.
54	Surgical care only	▪ Reimbursement is 80% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ When one physician performs a surgical procedure and another provides preoperative and/or postoperative management. The surgeon who performs the surgical procedure reports this modifier.
55	Postoperative Management Only	▪ Reimbursement is 20% of the 5-digit allowable. ▪ When one physician performed the postoperative management and another physician performed the surgical procedure.

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56	Preoperative Management Only	▪ Reimbursement is 1% of the 5-digit allowable. ▪ When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure. ▪ Blue KC requests the physician or practitioner use the appropriate level E/M code instead of the modified surgery or medicine code.
57	Decision for Surgery	▪ Reimbursement is 100% of the 5-digit allowable. ▪ An evaluation and management service that resulted in the initial decision to perform major surgery may be identified by adding the modifier '57' to the appropriate level of E/M service. ▪ Major surgery is defined as surgery that has a 90-day follow up period. ▪ Routine Preoperative Exceptions: New patient visits and consultations (99201-99205, 99241-99255) are separately reimbursed in addition to the global surgery payment even if performed 1 day prior or on the same day as a major surgery.
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period	▪ Reimbursement is 100% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ The physician may need to indicate that the performance of a procedure or service during the postoperative period was:

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		○ Planned prospectively at the time of the original procedure (staged) ○ More extensive than the original procedure; or ○ For therapy following a diagnostic surgical procedure. ▪ This modifier is not used to report the treatment of a problem that requires a return to the operating room (see Modifier -78).
59	Distinct Procedural Service	▪ Reimbursement is 100% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. It identifies procedures or services that are not normally reported together. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injury) not ordinarily encountered or performed on the same day by the same physician. However, when another already established or more descriptive modifier is appropriate, (e.g., LT/RT; T, F or E modifiers; -76, etc.) it should be used rather than Modifier -59,

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		unless the use of Modifier -59 best explains the circumstances. ▪ It should not be used when one of the -X{EPSU} modifier describes the reason for the distinct procedural service. It is not appropriate to bill both modifier -59 and an -X{EPSU} modifier on the same line. Per the CCI Narrative: This edit indicates that the two codes cannot be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic locations as recognized by coding conventions. However, if the two corresponding procedures are performed at the same patient encounter and in contiguous (contact or close association) structures, the modifier generally should not be utilized. ▪ If a -59 modified code would not have been considered a component of another code on the claim (e.g., the code would have paid without the modifier), the code will process with no need for further documentation. ▪ If the 5 digit base code is a component of another code on the claim and medical records were attached, the modifier will be reviewed for appropriateness. If the medical records were not attached, the claim line will be pended and the provider

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		may submit medical records for review of the appropriateness of the -59 modifier use. ▪ Blue KC will determine the appropriateness of the modifier based on the clinical information submitted to support its use. If it is determined to be appropriate, separate reimbursement will be made. If it is determined to be inappropriate, separate reimbursement will not be made.
62	Two Surgeons (Co-surgeons)	▪ Reimbursement is 75% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ Under certain circumstances, two surgeons (usually of different specialties) may function simultaneously as primary surgeons performing distinct parts of a total surgical service. ▪ Co surgery claims should be submitted with both surgeons using the modifier -62 on each appropriate line item code. Normally, each surgeon will be paid 75% of the allowable for the given procedure code. (This is derived from multiplying the total allowable by 150% and dividing by 2.) Multiple surgery reductions will still be taken. ▪ If the two surgeons act as co-surgeons, Modifier -62

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		rules apply. If one or both surgeons perform additional separate services, each report only those additional services provided. ▪ If one co-surgeon acts as an assistant for additional procedures, those services are reported with either Modifier -80 or -81.
63	Procedure Performed on Infants	▪ Reimbursement is 100% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. ▪ It should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory. Medicine sections of the CPT Coding Manual. Modifier -63 should not be reported on procedures performed on a fetus.
66	Surgical Team	▪ Reimbursement is 100% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ This modifier is used when highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of

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		complex equipment) are carried out under the "surgical team" concept. ▪ Modifier -66 is used by each participating surgeon to report his/her services. Each surgeon would report the same CPT code and modifier -66. ▪ If the surgery is billed with a modifier -66 and the documentation supports the need for team surgeons, claims will be considered by report. All claims for team surgery must contain sufficient information to support the medical necessity for a surgical team. Copies of this documentation should be sent with claims.
76	Repeat Procedure by Same Physician	▪ Reimbursement is 100% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ Modifier -76 indicates that a basic procedure or service had to be repeated by the same physician. Use this modifier to identify the procedure as a repeat rather than a duplicate service or billing error. Modifier -76 is easily misused, so note the following applications of other modifiers. ▪ An unrelated procedure or service by the same physician during the postoperative period is reported with Modifier -79.

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		○ For repeated clinical laboratory tests on the same day, see modifier -91.
77	Repeat Procedure by Another Physician	▪ Reimbursement is 100% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ Modifier -77 indicates that a basic procedure or service performed by one physician has been repeated by a second physician. This modifier usually is used during the postoperative period of the basic procedure. The second physician adds the modifier to the procedure code used by the first physician.
78	Return to the Operating Room for a Related Procedure During the Postoperative Period	▪ Reimbursement is 100% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ This modifier is used when the subsequent procedure is related to the first, and requires the use of the operating room. A new postoperative period does not begin with the use of the -78 modifier. ▪ If the patient is returned to the operating room after the initial operative session, even if on the same day as the original surgery, for one or more additional procedures as a result of complications from the original surgery, use modifier -78.

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		○ Do not use modifier -78 when the original surgery is repeated (see modifier -76) or when the repeat procedure is not performed in the operating room.
79	Unrelated Procedure or Service by the Same Physician During the Postoperative Period	▪ Reimbursement is 100% of 5-digit allowable. Multiple surgery guidelines may apply. ▪ Modifier -79 indicates that the procedure or service was performed during a postoperative period of another procedure but is not related to that surgery. Do not use Modifier -79 to report staged or related procedures (see Modifier -78) or services performed by the same physician during the assigned postoperative period of a procedure (see Modifier -76). ▪ Diagnosis codes must document the medical necessity of the service since the diagnosis for this service differs from those reported with the initial procedure.
80	Assistant Surgeon	▪ Reimbursement is 16% of the base code allowable for each line item code appropriately submitted with the -80 modifier. Multiple surgery guidelines may apply. ▪ Modifier -80 identifies surgical assistant services by a physician and is applied to the surgical procedure code(s).

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		▪ Services of a second assistant at surgery will be reviewed on an individual consideration basis. ▪ Assist at Surgery Allowed with Documentation: For codes identified as "Assist at Surgery Allowed with Documentation," ○ Documentation is required in the body of the operative report that describes what the assistant actually does. ○ It is not sufficient evidence of participation to list the assistant's name in the heading of the operative report. We require operative notes to contain sufficient information to support the medical necessity of an assistant at surgery. ○ We will deny claims if there is no accounting by the surgeon for what was performed by the assistant. ▪ For information regarding Minimum Assistant Surgeon, see Modifier -81. ▪ For information regarding Non- Physicians Assisting at Surgery, see Modifier –AS.
81	Minimum Assistant Surgeon	▪ Reimbursement is 12% of the base code allowable. Multiple surgery guidelines may apply. This percentage is consistent with the 25% reduction taken on primary

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		surgeons' charges submitted with the -52 modifier (reduced services). Assist at Surgery Allowed with Documentation: For codes identified as "Assist at surgery allowed with Documentation," ○ Documentation is required in the body of the operative report that describes what the assistant actually does. ○ It is not sufficient evidence of participation to list the assistant's name in the heading of the operative report. ○ We require operative notes to contain sufficient information to support the medical necessity of an assistant at surgery. ○ We will deny claims if there is no accounting by the surgeon for what was performed by the assistant. ▪ It identifies minimal surgical assistant services. This modifier is used when the services of a second or third assistant surgeon are required during a procedure. It may also be used when the assistant at surgery is not present for the entire procedure. ▪ This modifier is frequently used incorrectly to indicate that a non-physician assistant at surgery

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		provided the assistance (see –AS Modifier). However, Modifier -81 should only be applied when a physician performs the surgical service.
82	Assistant Surgeon (when qualified resident surgeon not available)	▪ Reimbursement is 16% of the base code allowable. Multiple surgery guidelines may apply. ▪ The unavailability of a qualified resident surgeon is a prerequisite for the use of this modifier. The assistant must provide documentation (certification) stating that a qualified resident was not available for this procedure and why the resident was not available. ▪ Assist at Surgery Allowed with Documentation: For codes identified as "Assist at Surgery Allowed with Documentation," Documentation is required in the body of the operative report that describes what the assistant actually does. ○ It is not sufficient evidence of participation to list the assistant's name in the heading of the operative report. ○ We require operative notes to contain sufficient information to support the medical necessity of an assistant at surgery.

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		○ We will deny claims if there is no accounting by the surgeon for what was performed by the assistant.
90	Reference (Outside) Laboratory	▪ Reimbursement is 100% of the 5-digit allowable. ▪ By appending the -90 modifier to the laboratory codes, the physician office is indicating the laboratory procedures were actually performed by an outside laboratory. CPT codes for use with modifier -90 are typically only those found in the range of 80048-89399
91	Repeat Clinical Diagnostic Laboratory Test - Used to indicate a test was repeated on the same day to obtain subsequent (multiple) test results	▪ Reimbursement is 100% of the 5-digit allowable. This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/ suppression testing). ▪ This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.
99	Multiple Modifiers	▪ Modifier -99 is used when two or more modifiers may be necessary to completely delineate a service. This modifier is not necessary

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		since the claims editing system accepts multiple modifiers on the same line.
AS		▪ Reimbursement is 12% of the base code allowable schedule before multiple surgery reductions are taken. No multiple surgery reductions will be taken on codes with the -AS modifier. ▪ Non-physicians (clinical nurse specialists, nurse practitioners or physician assistants only) may be reimbursed for serving as an assistant during surgery when the following criteria are met: o The individual is an employee of the primary operating surgeon o The procedure is one for which an assistant is valid o The charges for the assistant are submitted under the rendering practitioner identification number of the surgeon employer; and o All procedures are submitted with the correct CPT code and the "-AS" modifier. ▪ Separate benefit is not allowed for registered nurse first assists (RNFA), orthopedic physician assistants (OPA), licensed practical nurses (LPN), certified surgical technicians (CST), certified nurse, operating room (CNOR), certified surgical assistants (SA-C) or other licensed or non-licensed personnel employed by the physician

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		▪ practice, or when the above criteria are not met. If a separate charge is reported, it will be denied as a member contract exclusion. Assist at Surgery Allowed with Documentation: For codes identified as "Assist at Surgery Allowed with Documentation," ○ Documentation is required in the body of the operative report that describes what the assistant actually does. ○ It is not sufficient evidence of participation to list the assistant's name in the heading of the operative report. ○ We require operative notes to contain sufficient information to support the medical necessity of an assistant at surgery. ○ We will deny claims if there is no accounting by the surgeon for what was performed by the assistant.
CC	Procedure Code Change	▪ Use -CC to indicate the procedure code submitted was changed for administrative reasons or due to an incorrect code initially filed. ▪ Supporting documentation (office notes, operative report, etc.) must accompany a procedure code change.
E1, E2, E3, E4	Upper left eyelid, Lower left eyelid Upper right eyelid, Lower right eyelid	▪ Reimbursement is 100% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ Anatomic modifier to designate the area or part of

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		the body on which the procedure is performed.
FA, F1, F2, F3, F4, F5, F6, F7, F8, F9	Left hand, thumb Left hand, second digit Left hand, third digit Left hand, fourth digit Left hand, fifth digit Right hand, thumb Right hand, second digit Right hand, third digit Right hand, fourth digit Right hand, fifth digit	○ Reimbursement is 100% of the 5-digit allowable. Multiple surgery guidelines may apply. ○ Anatomic modifier to designate the area or part of the body on which the procedure is performed.
LT, RT	Left side Right side	▪ Reimbursement is 100% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ These modifiers are used to identify on which side of the body a procedure was performed. ▪ When the -LT or -RT modifiers are used on any line of a claim, all related lines on that claim must also have the appropriate -LT/-RT modifier appended to ensure accurate payment of the claim. ▪ When billing bilateral procedures that are performed in conjunction with other multiple surgery procedures, the bilateral procedure should be

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		submitted on two lines using the -LT and -RT modifiers instead of on one line with the -50 modifier. ▪ Billing on two lines will ensure the appropriate multiple surgery pricing for each procedure reported on the claim. When only one set of bilateral procedures are performed, submit on one line using the -50 modifier.
P1	A normal healthy patient	
P2	A patient with a mild systemic disease	
P3	A patient with severe systemic disease	▪ Additional reimbursement for these modifiers is for the -P3 at one additional unit.
P4	A patient with severe systemic disease that is a constant threat to life	▪ Additional reimbursement for these modifiers is for the –P4 at two additional unit.
P5	A moribund patient who is not expected to survive without the operation	▪ Additional reimbursement for these modifiers is for the –P5 at three additional unit.
P6	A declared brain-dead patient	
QK QX	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals	▪ Reimbursement is determined by anesthesia pricing guidelines. ▪ Separate reimburse is not made for the -QK and -QX modified codes. ▪ When billed, a redundant edit will be applied. ▪ Reimbursement is made to one anesthesiologist for the

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	Qualified non-physician anesthetist with medical direction by a physician	anesthesia service provided based on ASA units plus time units.
SH SJ	Second concurrently administered infusion therapy Third or more concurrently administered infusion therapy	▪ -SH and -SJ Modifiers for Home Infusion Therapy. ▪ When multiple home infusions are administered, use modifiers -SH or -SJ. ▪ -SH identifies the second concurrently administered infusion therapy. ▪ -SJ identifies the third or more concurrently administered infusion therapy. ▪ The Blue KC reimbursement is based on the following: o First or highest valued procedure -100% of fee schedule amount. o Second procedure - 50% of fee schedule amount (-SH modifier) o All subsequent procedures –25% of fee schedule amount (-SJ modifier).
TA, T1, T2, T3, T4, T5, T6, T7, T8, T9	Left foot great toe, Left foot second digit, Left foot third digit, Left foot fourth digit, Left foot fifth digit, Right foot great toe,	▪ Reimbursement is 100% of the 5-digit allowable. Multiple surgery guidelines may apply. ▪ Anatomic modifier to designate the area or part of the body on which the procedure is performed.

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	Right foot second digit, Right foot third digit, Right foot fourth digit, Right foot fifth digit	
TC	Technical Component Only	• Reimbursement varies. Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding Modifier -TC to the usual procedure code. Technical component charges are institutional charges and not billed separately by physicians.
X[EPSU]	XE Separate Encounter	▪ Reimbursement is 100% of the 5-digit allowable. Multiple surgery guidelines may apply.
	XS Separate Structure	▪ A service that is distinct because it occurred during a separate encounter.
	XP Separate Practitioner	▪ A service that is distinct because it was performed on a separate organ/structure.
	XU Unusual Non	▪ A service that is distinct because it was performed by a different practitioner.
	Overlapping Service	▪ A service that is distinct because it does not overlap usual components of the main service.

MODIFIER	MODIFIER DESCRIPTION	PRICING/FUNCTIONALITY
		▪ -X{EPSU} Modifiers are used in place of the -59 modifier. ▪ If -X{EPSU} code would not have been considered a component of another code on the claim (e.g., the code would have paid without the modifier), the code will process with no need for further documentation. ▪ Blue Cross and Blue Shield of Kansas City will determine the appropriateness of the modifier based on the clinical information submitted to support its use. If it is determined to be appropriate, separate reimbursement will be made. If it is determined to be inappropriate, separate reimbursement will not be made.
RR	DME Rental	▪ Reimbursement is 10% of the 5-digit allowable.

Documentation Submission

Documentation must identify and describe the procedures performed and time spent for each service. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

The following applies to all claim submissions;
All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all health services is subject to the current Blue KC Medical Policy criteria, policies found under Provider Payment Policy, Provider Office Guide and all other provisions of the Provider Service Agreement. In the event that any new codes are developed during the course of the Provider's Agreement, such new codes will be paid according to the standard or applicable Blue KC fee schedule until such time as a new agreement is reached and supersedes the provider's current agreement. Eligible services will be subject to the subscriber benefits, Blue KC fee schedule amount, and any coding edits.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated, if appropriate, using the appropriate facility or non-facility components, based on the site of service identified, as submitted by provider.

Policy History

DATE	DESCRIPTION
	Approval Date
7/1/2019	Effective Date