SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.24 MODIFIERS

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

MODIFIERS

A modifier provides the means by which the reporting provider can indicate a service or procedure has been performed and has been altered by some specific circumstance but not changed in its definition or code.

To ensure you receive the most accurate payment for services you render, Blue Cross recommends using modifiers when you file claims. For Blue Cross claims filing, modifiers, when applicable, always should be used by placing the valid CPT or HCPCS modifier(s) in Block 24D of the CMS-1500 claim form. A complete list of valid modifiers is listed in the most current CPT or HCPCS code book. Please ensure that your office is using the current edition of the code book reflective of the date of service of the claim. If necessary, please submit medical records with your claim to support the use of a modifier.

Please use the following tips to avoid the possibility of rejected claims:

- Use valid modifiers. Blue Cross considers only CPT and HCPCS modifiers that appear in the current CPT and HCPCS books as valid.
- Indicate the valid modifier in Block 24D of the CMS-1500 claim form. We collect up to four modifiers per CPT and/or HCPCS code.
- Do not use other descriptions in this section of the claim form. In some cases, our system may read the description as a set of modifiers and this could result in lower payment for you.
- Avoid excessive spaces between each modifier.
- Do not use dashes, periods, commas, semicolons or any other punctuation in the modifier portion of Block 24D of the CMS-1500 claim form.

Modifier Guidelines

The table on the next pages lists some of the modifiers that Blue Cross accepts and their reimbursement schedule. Not all modifiers affect reimbursement.

If you have any questions about billing with modifiers, please call Provider Relations.

CPT/HCPCS Modifiers	Description	Blue Cross Use
22*	Unusual procedural service	May pay up to 20% additional payment will be considered for minor additional circumstances; 25% additional payment will be considered for very unusual additional circumstances. Additional documentation required with claim.
24	Unrelated evaluation and management service by the same physician during a postoperative session	Pays separate allowable charge. Supportive documentation required in medical record.
25*	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	May pay separate allowable charge. Supportive documentation required in medical record.

26*	Professional component	Pays professional component of the allowable charge
50*	Bilateral procedure	Payment based on 150% of allowable charge for applicable codes for primary bilateral procedures; secondary bilateral procedures are reimbursed at 75% of the allowable charge.
51	Multiple procedures	Generally pays primary or highest allowable procedure at 100% of allowable charge and rest at 50% of allowable charge
52	Reduced services	Allowable charge will be reduced by 20%
53	Discontinued procedure	Pays 50% of allowable charge for applicable codes
54	Surgical care only	Pays 80% of allowable charge for applicable codes
55	Post-operative management only	Pays 20% of allowable charge for applicable codes
56	Pre-operative management only	Pays 10% of allowable charge for applicable codes
57	Decision for surgery	Pays separate allowable charge
59*	Distinct procedural service	May pay separately
62*	Two surgeons	If allowed, pays 120% of allowable charge divided between both surgeons
78	Returns to the operating room for a related procedure during the post-operative period	Pays 80% of allowable charge for applicable codes
80*	Assistant surgeon (physician only)	Pays 20% of allowable charge for applicable codes
81*	Minimum assistant surgeon (physician only)	Pays 20% of allowable charge for applicable codes
82*	Assistant surgeon when qualified resident surgeon not available (physician only)	Pays 20% of allowable charge for applicable codes
AS*	Nurse practitioner, physician assistant or clinical nurse specialist for assistant at surgery	Pays at 85% of assistant surgeon allowable charge for applicable codes
MS	Six-month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty	Pay rental amount once every six months after purchase price reached for applicable codes
NU	New equipment	Payment based on purchase allowable charge
RR	Rental	Payment based on rental allowable charge up to purchase allowable charge
SA*	Nurse practitioner or physician assistant rendering service in collaboration with a physician	Pays at 85% of the allowable charge
SB	Nurse midwife	Pays at 85% of the allowable charge
TC*	Technical component	Pays technical component of the allowable charge

*See the end of this section for additional guidelines on how to bill this modifier.

Modifier 22

When using Modifier 22 (unusual procedural services), please attach to the claim form a medical or operative report and an explanation of why the modifier is being submitted or copies of applicable medical records. Without this information, the modifier will not be recognized, and the standard allowable charge will be applied without review or consideration of the modifier. It is not appropriate to bill Modifier 22 for an office visit, X-ray, lab or evaluation and management services.

Modifier 25

Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service. May pay separate allowable charge. Supportive documentation required in medical record.

Modifiers 26 and TC

Modifiers are used to report both the professional and technical components for radiology, pathology and laboratory services. Professional component only or technical component only codes do not require Modifier 26 or TC.

Modifier rules are as follows:

- Modifier 26 - used when billing separately for the **professional** component of a service.
- Modifier TC - used when billing separately for the **technical** component of a service.
- Total component (global) billing does not require a modifier.
- To ensure prompt and correct payment for your services, always use the appropriate modifier.

When billing for diagnostic and therapeutic hospital-based physician services, you should only bill the professional component and such billing should be submitted on the CMS-1500 claim form. Blue Cross will not separately reimburse technical components associated with hospital inpatient and outpatient services. Reimbursement for these services are included in the hospital's payment.

The technical and/or professional components for all radiology and other imaging services may be billed by the physician only if he/she actually renders the service. The physician may not bill Blue Cross for the technical and/or professional component of any diagnostic test or procedure, including but not limited to, X-rays, ultrasound, or other imaging services, computerized axial tomography or magnetic resonance imaging by utilizing another entity's NPI. The referring provider may not receive compensation, directly or indirectly, from the provider who rendered the service.

Modifier 33

Providers can append Modifier 33 to indicate that the screening colonoscopy (45378) was converted to a polypectomy (45388). In this scenario Modifier 33 is appended to 45388 to ensure that the claim is paid correctly. **Modifier 33 will impact how the claim is paid only for colonoscopy procedures**. Modifier 33 should not be applied to nonpreventive colonoscopies (done to evaluate signs, symptoms, follow-up or existing conditions).

Modifier 50 - Billing Single Bilateral Procedures

- **Single Bilateral (Modifier 50)** procedures can anatomically be done bilaterally only once per session.
- **Multiple Bilateral (Modifier 50)** procedures can anatomically be done bilaterally multiple times per session.

Correct submission of a bilateral procedure is the code on one line with Modifier 50 and "1" in the units field. Claim lines submitted with both the LT and RT modifiers will be considered incorrectly billed. Modifier 50 is not applicable to radiology services. For radiology services, please bill the appropriate number of units.

For all professional and facility claims, bilateral procedures are reimbursed as follows:

1. The primary bilateral procedures are reimbursed at 150% of the allowable charge.
2. The secondary bilateral procedures are reimbursed at 75% of the allowable charge.

Proper billing of bilateral procedures ensures correct reimbursement and eliminates the need for refund requests and payment adjustments.

Modifier RT and LT Clarification:

- Modifiers RT and LT are informational modifiers only and should not be used when Modifier 50 applies.
- Modifier 50 should be used to report bilateral procedures that are performed on both sides at the same operative session as a single line item.

Modifier 59

The primary purpose of Modifier 59 is to report two or more procedures that are being performed at different anatomic sites or for different patient encounters by the same provider on the same date of service. This modifier should not be used to bypass an edit unless the proper criteria for its use are met and documentation in the patient's medical record clearly supports this criteria and the use of Modifier 59. Modifier 59 should not be appended to an E&M service. To report a separate and distinct E&M service with a non-E&M service performed on the same date, see Modifier 25.

CMS has established four HCPCS modifiers to define specific subsets for Modifier 59. For professional claims, Blue Cross may allow the same incidental and mutually exclusive edit overrides for modifiers XE, XP, XS and XU as it does for Modifier 59.

- XE - Separate Encounter - A service that is distinct because it occurred during a separate encounter.
- XP - Separate Practitioner - A service that is distinct because it was performed by a different practitioner.
- XS - Separate Structure - A service that is distinct because it was performed on a separate organ structure.
- XU - Unusual Non-Overlapping Service - The use of a service that is distinct because it does not overlap usual components of the main service.

Modifier 62

Co-surgery is defined as two surgeons of different specialties operating together to perform a single surgery, usually expressed under one CPT code. For co-surgeries, Blue Cross allows 120% of the allowable charge and divides that amount equally between the two surgeons. Additional assistants not reimbursed and are considered included in the services already paid to the physician(s).

Modifiers 73 and 74 - Discontinued Services *(postponing surgery after patient is prepped)*

- Modifier 73 - used when a procedure is discontinued and anesthesia WAS NOT administered. A 50% reduction is applied to the allowable charge.
- Modifier 74 - used when a procedure is discontinued and anesthesia WAS administered. Blue Cross applies the full allowed amount (no reduction is applied).

Modifiers TA and T1-T9 Site Specific

When billing toe or toenail surgeries, Modifiers TA and T1-T9 are necessary to ensure services are processed and paid correctly.

HCPCS Level II toe Modifiers TA and T1-T9 are anatomical modifiers that describe procedures performed on the right and left foot digits. It is incorrect to additionally append Modifiers LT and/or RT. It is also incorrect to use Modifier 59 and/or Modifier 59 subset "X modifiers" (XE, XS, XP, XU).

Failure to use these modifiers appropriately may result in claims denial. Additionally, post audits will be performed and will result in recoupments if documentation reviewed supports unbundling by incorrect use of Modifiers 59, XE, XS, XP, XU, LT and RT.

Modifiers AS, 80, 81 and 82 Billing for Surgical Assistant Services

The following provider types may be reimbursed for procedures approved to have an assistant at surgery:

- Certified registered nurse first assistants (CRNFA)
- Physician assistants (PA)
- Nurse practitioners (NP)
- Registered nurse first assistants (RNFA)

They should bill under their provider number with Modifier AS when billing for surgical assistant service. They should not use Modifiers 80, 81 or 82. These modifiers should be used by physicians only. Reimbursement will be 85% of the assistant surgeon allowable charge. BCBSLA does not provide additional reimbursement for assistant services provided by certified surgical first assistant (CSFA).

Please Note: FEP member benefits for surgical assistant services provided and billed by qualified non-physician professionals (e.g., RNFAs or PAs) may be provided **as long as such services fall within the scope of the provider's licensure**.

Modifier SA

Nurse practitioners and physician assistants must submit claims for their services using their individual NPI. For nurse practitioners and physician assistants providing services under an urgent care center or emergency room physician number, Modifier SA should be appended to the services billed.