MODIFIERS

Policy # 17
Implementation Date:1/1/02
Review Dates:11/13/24
Revision Dates: 6/30/05, 1/8/10, 4/26/10, 10/1/10, 8/21/14, 1/23/25

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

Description

Modifiers are used in conjunction with CPT and HCPCS codes to report additional information. Select Health accepts all HIPAA compliant modifiers for adjudication if they are valid with the CPT codes billed but may not recognize them for payment.

COMMERCIAL PLAN POLICY/CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

The following is a list of modifiers that **may** affect claims adjudication. If a modifier affects pricing, then the fee schedule for the five-digit code will be changed based on the modifier reported. If a modifier affects editing, then specific edits that may apply for a five-digit code may not apply if one of these modifiers is appended. Some modifiers flag claims for manual review to adjudicate appropriate benefits.

Modifier	Affects Clinical Editing			Affects Pricing			Additional Info or Review
	Commercial	Medicare	Medicaid	Commercial	Medicare	Medicaid	
22 - Increased Procedural Services	NO	NO	NO	MAYBE	MAYBE	MAYBE	Manual review is required to determine if additional payment will be made based on documentation. Documentation is required.
23 - Unusual Anesthesia:	NO	NO	NO	NO	NO	NO	No manual review necessary

24 - Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period:	YES	YES	YES	NO	NO	NO	If billed on Evaluation and Management codes during the global period of an unrelated procedure, modifier 24 may allow payment for E/M service. Manual review and documentation are required
25 - Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service:	YES	YES	YES	NO	NO	NO	When an E/M service is performed on the same day of an XXX, 000, 010, or 090 day global procedure and is above and beyond what is normally included in the procedure and represents a separately identifiable service modifier -25 may allow payment for the E/M service. Manual review and documentation are required
26 - Professional Component TC – Technical Component	YES	YES	YES	YES	YES	YES	No manual review is necessary for the most part. If one provider is billing with a 26 and another or the same provider is also billing a global (26 + TC), review will be required to determine if both claims are appropriate based on documentation for both reported codes.
27 - Multiple Outpatient Hospital E/M Encounters on the Same Date	NO	NO	NO	NO	NO	NO	
47 - Anesthesia By Surgeon	YES	NO	NO	YES	YES	YES	Manual review required for pricing. Modifier 47 should be billed on code for the procedure.

50 - Bilateral Procedure	NO	NO	NO	NO	YES	NO	For all lines of business Select Health will determine if the 50 modifier is appended appropriately. For proper reimbursement for bilateral services on Commercial and Medicaid lines of business, Select Health requires that the procedure be reported on two separate lines one with RT modifier and one with LT modifier, instead of billing modifier 50. For proper reimbursement for bilateral services on Medicare line of business, Select Health requires that the procedure be reported on one line with modifier 50.
51 - Multiple Procedures	NO	NO	NO	NO	NO	NO	No manual review necessary. System will automatically price multiple surgeries.
52 - Reduced Services	NO	NO	NO	YES	YES	YES	An automatic 25% reduction will apply. **This is the same for all lines of business.**
53 - Discontinued Procedure	NO	NO	NO	YES	YES	YES	An automatic 25% reduction will apply. **This is the same for all lines of business.**

54 - Surgical Care Only	YES	YES	YES	YES	YES	YES	Payment will be based off Medicare's percentage of the service that is for surgical and preoperative care.
55 - Postoperative Management Only	YES	YES	YES	YES	YES	YES	Payment will be based off Medicare's percentage of the service that is for postoperative management only.
56 - Preoperative Management Only	YES	YES	YES	YES	YES	YES	Payment will be based off Medicare's percentage of the service that is for preoperative management only.
57 - Decision for Surgery	YES	YES	YES	NO	NO	NO	When an E/M service is performed on the same day as a 090-day global procedure and the decision for surgery is made through the evaluation and management service, modifier 57 may allow payment for the E/M service.
58 - Staged or Related Procedure or Service by the Same Physician During the Postoperative Period	YES	YES	YES	NO	NO	NO	No manual review necessary

59 - Distinct Procedural Service	YES	YES	YES	NO	NO	NO	For all lines of business, Select Health's system may or may not override edits initially. Modifier 59 should be reported on codes that regularly deny if documentation supports the criteria outlined in policy #05, Distinct Procedural Service Modifiers (59, XE, XP, XS, XU) Modifier 59 will be reviewed on appeal if it is denied.
62 - Two Surgeons	YES	YES	YES	YES	YES	YES	Pays 62.5% of the Fee schedule to each physician. Each physician needs to bill the same code with 62 modifier and should have their own signed operative report (or one operative report signed by both physicians) that reports the portion of the procedure they each performed. **This is the same for all lines of business.**
63 - Procedure Performed on Infants less than 4 kg	NO	NO	NO	MAYBE	MAYBE	MAYBE	A manual review is required to determine if additional payment will be made based on documentation. Documentation is required.
66 - Surgical Team	YES	YES	YES	YES	YES	YES	Pays 60% of the fee schedule to each physician. Each physician should have their own signed operative report that reports the portion of the procedure they performed. **This is the same for all lines of business.**

73 – Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia	YES	YES	YES	NO	NO	NO	Manual review is required and may decrease allowed amount based on documentation.
74 – Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia	NO	NO	NO	NO	NO	NO	Manual review is required and may decrease allowed amount based on documentation.
76 Repeat Procedure by Same Physician	YES	YES	YES	NO	NO	NO	Manual review may be required to allow additional charges if documentation shows that the charges are not duplicates.
77 Repeat Procedure by Another Physician	YES	YES	YES	NO	NO	NO	Manual review may be required to allow additional charges if documentation shows that the charges are not duplicates.
78 Return to the Operating Room for a Related Procedure During the Postoperative Period	YES	YES	YES	YES	YES	YES	No manual review necessary.
79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period	YES	YES	YES	NO	NO	NO	No manual review necessary.

80/81/82/AS Assistant Surgeon	YES	YES	YES	YES	YES	YES	Assistant surgeon modifiers should not be billed by both the primary surgeon and the assistant surgeon. Credentialed PAs or NPs may use the AS modifier for payment when assisting in surgery. For Commercial and Medicaid, **80 and 82** modifiers pay 20% of fee schedule. For Medicare, 80 and82 modifiers pay 16% of fee schedule. The **81** modifier pays 16% of the fee schedule for all lines of business. Commercial and Medicaid pay 12% of fee schedule for the **AS** modifier. Medicare pays13.6% of the fee schedule for the **AS** modifier.
90 Reference (Outside) Laboratory	NO	NO	NO	NO	NO	NO	No manual review necessary.
91 Repeat Clinical Diagnostic Laboratory Test	NO	NO	NO	NO	NO	NO	Manual review may be required for duplicate charges.
99 Multiple Modifiers	NO	NO	NO	NO	NO	NO	Requires manual review to see what modifiers this replaces.
P1: A normal healthy patient	NO	NO	NO	NO	NO	NO	No manual review necessary.
P2: A patient with mild systemic disease	NO	NO	NO	NO	NO	NO	No manual review necessary.

P3: A patient with severe systemic disease	NO	NO	NO	YES	YES	YES	No manual review necessary.
P4: A patient with severe systemic disease that is a constant threat to life	NO	NO	NO	YES	YES	YES	No manual review necessary.
P5: A moribund patient who is not expected to survive without the operation	NO	NO	NO	YES	YES	YES	No manual review necessary.
P6: A declared brain-dead patient whose organs are being removed for donor purposes	NO	NO	NO	NO	NO	NO	No manual review necessary.
							(Modifier terminated December 2016)
E1: Upper left eyelid	YES	YES	YES	NO	NO	NO	No manual review necessary.
E2: Lower left, eyelid	YES	YES	YES	NO	NO	NO	No manual review necessary.
E3: Upper right eyelid	YES	YES	YES	NO	NO	NO	No manual review necessary.
E4: Lower right eyelid	YES	YES	YES	NO	NO	NO	No manual review necessary.
F1: Left hand, second digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
F2: Left hand, third digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
F3: Left hand, fourth digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
F4: Left hand, fifth digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
F5: Right hand, thumb	YES	YES	YES	NO	NO	NO	No manual review necessary.

F6: Right hand, second digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
F7: Right hand, third digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
F8: Right hand, fourth digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
F9: Right hand, fifth digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
FA: Left hand, thumb	YES	YES	YES	NO	NO	NO	No manual review necessary.
LT: Left side	YES	YES	YES	NO	NO	NO	No manual review necessary.
RT Right side	YES	YES	YES	NO	NO	NO	No manual review necessary.
T1: Left foot, second digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
T2: Left foot, third digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
T3: Left foot, fourth digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
T4: Left foot, fifth digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
T5: Right foot, great toe	YES	YES	YES	NO	NO	NO	No manual review necessary.
T6: Right foot, second digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
T7: Right foot, third digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
T8: Right foot, fourth digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
T9: Right foot, fifth digit	YES	YES	YES	NO	NO	NO	No manual review necessary.
TA: Left foot, great toe	YES	YES	YES	NO	NO	NO	No manual review necessary.
NU New equipment	NO	NO	NO	YES	YES	YES	No manual review necessary.
RR Rental	NO	NO	NO	YES	YES	YES	No manual review necessary.
UE Used durable medical equipment	NO	NO	NO	YES	YES	YES	No manual review necessary.
HCPCS Modifiers	**Affects Clinical Editing**			**Affects Pricing**			**Additional Info or Review**

	Commercial	Medicare	Medicaid	Commercial	Medicare	Medicaid	
BO Orally administered nutrition, not by feeding tube	NO	NO	NO	YES	YES	YES	
EY No physician or other licensed health care provider order for this item or service	YES	YES	YES	YES	YES	YES	No manual review necessary.
GF Nonphysician (e.g., nurse practitioner (NP), certified registered nurse anesthetist (CRNA), certified registered nurse (CRN), clinical nurse specialist (CNS), physician assistant (PA)) services in a critical access hospital	NO	NO	NO	YES	YES	YES	No manual review necessary.
GL Medically unnecessary upgrade provided instead of standard item, no charge, no advance beneficiary notice (ABN)	YES	YES	YES	YES	YES	YES	No manual review necessary.

GQ Via asynchronous telecommunications system	NO	NO	NO	NO	NO	NO	
GT/95 Via interactive audio and video telecommunication systems	NO	NO	NO	NO	NO	NO	Medicare line of business: Effective October 1, 2018, the GT modifier is only allowed on facility claims billed by Critical Access Hospitals (CAH).
HD Pregnant/parenting women's program	YES	YES	YES	YES	YES	YES	No manual review necessary.
HJ Employee assistance program	YES	YES	YES	YES	YES	YES	No manual review necessary.
HM Less than bachelor's degree level	YES	YES	YES	YES	YES	YES	No manual review necessary.
KL, KF, KC	NO	NO	NO	NO	NO	NO	
LL Lease/rental (Use the LL modifier when DME equipment rental is to be applied against the purchase price)	NO	NO	NO	NO	NO	NO	
MS Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty	NO	NO	NO	YES	YES	YES	No manual review necessary.
NR New when rented (use the NR modifier when DME which was new at the time of rental is subsequently purchased)	YES	YES	YES	NO	NO	NO	

Q0 Investigational clinical service provided in a clinical research study that is in an approved clinical research study	NO	NO	NO	YES	YES	YES	No manual review necessary.
Q5 Service furnished under a reciprocal billing arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area	NO	NO	NO	NO	NO	NO	No manual review necessary.
Q6 Service furnished under a fee-for-time compensation arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area	NO	NO	NO	NO	NO	NO	No manual review necessary.
SE State and/or federally funded programs/services	YES	YES	NO	NO	NO	NO	No manual review necessary.
SG Ambulatory surgical center (ASC) facility service	YES	YES	YES	NO	NO	NO	
SL State supplied vaccine	YES	YES	YES	YES	YES	NO	No manual review necessary.
SU Procedure performed in physician's office (to denote use of facility and equipment)	YES	YES	YES	NO	NO	NO	No manual review necessary.

CC corrected claim	NO	NO	NO	NO	NO	NO	No manual review necessary.
TM Modifier	YES	YES	YES	YES	YES	YES	

SELECT HEALTH MEDICARE (CMS)

See table above.

SELECT HEALTH COMMUNITY CARE (MEDICAID)

See table above.

Applicable Codes

Modifiers	Descriptions
See above	See above

Sources

1. *Current Procedural Terminology (CPT®)* (2024). – American Medical Association
2. ICD-10-CM Coding Guidelines. (2025, January 1). Retrieved on November 14, 2024, from 2024 Common Guidelines effective April 2024.fm
3. Utah Department of Health. (2014, October 1). PHYSICIAN SERVICES MANUAL. Retrieved on November 14, 2024, from PhysicianServices1-22.pdf

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Select Health® makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. Select Health updates its Coverage Policies regularly, and reserves the right to amend these policies without notice to healthcare providers or Select Health members.

Members may contact Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Coverage Policy may call Select Health Provider Relations at (801) 442-3692.