



Modifier Usage Guide

What Your Practice Needs to Know

Blue Cross & Blue Shield of Mississippi has relied on information publicized by the American Medical Association in the presentation of usage of CPT modifiers. The information contained therein should not be used in lieu of the members specific plan language but used as a tool to understand the acceptance and reimbursement of CPT modifiers for a Blue Cross & Blue Shield of Mississippi member.

Modifier 22 Usage

CPT4 Definition:

Modifier 22 - Procedural Service

- The purpose of this modifier is to report services (surgical or nonsurgical) when the work required to provide a service is substantially greater than typically required.
- This **modifier must** be used **only** when additional work factors requiring the **physician's** technical skill involve significantly increased physician work, time, and complexity of than when the procedure is normally performed.
 - "Substantially Greater" refers to increased intensity, time, technical difficulty of procedure, severity of patient's condition, and physical and mental effort required, etc.
 - Trauma extensive enough to complicate the procedure and cannot be reported with additional procedures.
 - Significant scarring requiring extra time and work.
 - Extra work resulting from morbid obesity.
 - Increased time resulting from extra work by the physician.
- Procedure codes with modifier 22 appended will price at 120% of the allowable charge.
- This modifier may be used with codes in the following sections:
 - Anesthesia (00100-01999)
 - Surgery (11100-69990)
 - Radiology (70010-79999)
 - Laboratory and pathology (80047-89356)
 - Medicine (90281-99607)
- This modifier is not appended to ELM services (99201-99499).

Clinical Information Requirements:

- Medical records must be available upon request.
- Clinical information documented in the patient's medical records must support the use of this modifier.

Modifier 25 Usage

CPT4 Definition:

Modifier 25 - Significant, Separately Identifiable evaluation and management service by the same physician on the same day of the procedure or other service.

- The purpose of this modifier is to indicate that a significant, separately identifiable E/M service was performed by the same physician on the same day of a procedure due to the patient's condition requiring it to be performed.
- The E/M service has to be above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. See the Surgery Guidelines in the most recent issue of the CPT manual for the definition of "global surgical package."
- Different diagnoses are not required for reporting E/M service on the same date.
- This modifier **must not** be used to report an E/M service that resulted in a decision to perform surgery.
- E/M service must meet key components: history, examination, medical decision making.
- Modifier 25 must only be appended to the E/M codes.

CPT4 Surgical Package Definition:

In defining the specific services 'included' in a given CPT surgical code, the following services are always included in addition to the operation per se:

- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia.
- Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure (including history and physical).
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians.
- Writing orders (e.g. ordering lab, x-rays, etc.)
- Evaluating the patient in the post-anesthesia recovery area.
- Typical postoperative follow-up care.

Modifier 25 Usage (Continued)

Clinical Information Requirements:

- Medical records are not required with the claim, but must be available upon request.
- Documentation must support the chosen E/M service level code and be referenced by a diagnosis code, confirming that the E/M service billed was above and beyond the E/M services included in the procedure and over and above the services normally included in the pre-op and post-op for the procedure.
 - o Normal Pre-operative work includes:
 - Assessing the site and condition of the problem area
 - Explaining the procedure
 - Obtaining formal consent

Modifier 25 Guidelines:

Blue Cross & Blue Shield of Mississippi does not allow separate reimbursement of Preventive Wellness Visits on the same day as an illness visit.

E/M services that are necessary for the performance of a medical procedure are included in payments for the procedure. Exception is made for payment of an E/M if a provider performs an E/M service on the same day as a procedure that is significant, separately identifiable, and above and beyond the usual postoperative care associated with the procedure.

Blue Cross & Blue Shield of Mississippi recognizes the additional work involved with providing multiple services on the same date. For the following situations modifier -25 is accepted when the provider provides other services on same day of the procedure or unrelated diagnosis that are clearly different requiring E/M services above and beyond the normal pre-operative or post-operative care.

- Laboratory test
- Diagnostic x-ray
- E/M billed is a consultation
- E/M billed is an observation code
- Other diagnoses addressed that are unrelated to reason for the encounter.

Additional documentation may be requested for other services performed on the same day.

Modifier 33 Usage

CPT4 Definition:

Modifier 33 - Preventive Services

- The purpose of this modifier is to report 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).
- For separately reported services specifically identified as preventive, the modifier **must** not be used.
- CPT Modifier is applicable to the identification of preventive services without cost-sharing in these four categories.
 1. 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: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm;
 2. 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;
 3. Preventive care and screenings for children as recommended by Bright Futures (American Academy of Pediatrics) and Newborn Testing (American College of Medical Genetics) as supported by the Health Resources and Services Administration; and
 4. 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.

Clinical Information Requirement

- Medical records are not required with the claim, but must be available upon request.
- For information concerning Preventive Services modifier, please refer to our Medical Policy, “Preventive Health Services”.
- Modifier 33 is only valid and allowed on codes listed in the above medical policy.

Modifier 50 Usage

CPT4 Definition:

Modifier 50 - Procedure

- The purpose of this modifier is to report bilateral procedures performed at the same operative session by the same physician.
- Modifier 50 must only be applied to services and/or procedures performed on identical anatomic sites, aspects, or organs.
- Modifier 50 **cannot** be used when the code description indicates unilateral or bilateral.

Modifier 50 Guidelines:

- Bilateral modifiers must be submitted by repeating the appropriate code on two separate lines with modifier -50 appended to the second line.
- Reimbursement is subject to 100% of the allowable charge for the first line and 50% of the allowable charge for the second line.

Clinical Information Requirements:

- Medical records are not required with the claim, but must be available upon request.

Modifier 51 Usage

CPT4 Definition:

Modifier 51 - Procedures

- The purpose of this modifier is to report multiple procedures performed at the same session by the same physician.
- Modifier -51 (multiple procedures) must be used to indicate instances when multiple procedures, other than E/M services, physical medicine and rehabilitation services, or provision of supplies (e.g., vaccines), are performed at the same session by the same provider.

Modifier 51 Guidelines:

- BCBSMS considers the surgical procedure with the highest allowable amount the primary (first) procedure. Medicare uses the RVU for this determination. The RVU is a factor in determining the allowed amount for the BCBSMS fee schedule.
- Multiple surgeries must be submitted by appending the modifier 51 to the codes with lower allowed amounts.
- If the same procedure is provided multiple times and it is appropriate to submit the code twice, and the code has the highest allowed amount, then the code must be submitted on separate lines and append modifier -51 to the second, third, etc. line as appropriate. The primary (first) procedure must be on one line with one unit.
- BCBSMS applies multiple surgery reduction only to codes that fall under all of the following criteria:
 - Codes that are **not** add-on codes,
 - Codes that are **not** modifier -51 exempt and
 - Codes that are surgical procedures
- Reimbursement is subject to 100% of the allowable charge for the primary code and 50% of the allowable charge for each additional surgery code.

Clinical Information Requirements:

- Medical records are not required with the claim, but must be available upon request.

Modifier 52 Usage

CPT4 Definition:

Modifier 52 - Reduced Services

- This modifier is used to report a service or procedure that is partially reduced or eliminated at the physician's election.
- Modifier 52 is appended to the code for the reduced procedure.
- Modifier 52 is **not** used to report an elective cancellation of a procedure before anesthesia induction and/or surgical preparation in the operating suite.
- Modifier 52 **cannot** be used if the procedure is discontinued after administration of anesthesia.
- Procedure codes with modifier 52 will price at 50% of the allowable charge.

Clinical Information Requirements:

- Medical records are not required with the claim, but must be available upon request.
- Clinical information documented in the patient's records must support the use of this modifier.
- Documentation should include a statement indicating in what way the procedure or service was reduced.

Modifier 53 Usage

CPT4 Definition:

Modifier 53 - Discontinued Procedure

- Modifier 53 **must** be appended to a surgical code or medical diagnostic code when the procedure is discontinued because of extenuating circumstances.
- This modifier is used to report services or procedure when the services or procedure is discontinued after anesthesia is administered to the patient.
- This modifier is **not** used to report an elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.
- Modifier 53 **cannot** be used when a laparoscopic or endoscopic procedure is converted to an open procedure.
- Modifier 53 **cannot** be appended to E/M codes.
- Modifier 53 will price the procedure at 30% of the allowable charge.

Clinical Information Requirements:

- Medical records are not required with the claim, but must be available upon request.
- Clinical information documented in the patient's records must support to use of this modifier.
- Documentation must include a statement indicating at what point the procedure was discontinued. The extenuating circumstances preventing the completion of the procedure must also be documented.

Modifier 54 Usage

CPT4 Definition:

Modifier 54 - Surgical Care Only

- Modifier 54 is reported when one physician performed a surgical procedure only; another physician provides the preoperative and/or postoperative management. Modifier 54 is appended to the surgical code. The physician is paid a portion of the global package.
- Modifier 54 **must only** be appended to the surgical procedure codes.
- Procedure codes with modifier 54 will price at 70% of the allowable charge.

Clinical Information Requirements:

- Medical records are not required with the claim, but must be available upon request.
- Clinical information documented in the patient's records must support to use of this modifier.

Modifier 55 Usage

CPT4 Definition:

Modifier 55 - Postoperative Management Only

- Modifier 55 is reported when one physician performed the postoperative management only; another physician performed the surgical procedure. Modifier 55 is appended to the surgical code. The physician is paid a portion of the global package.
- Modifiers 55 **must only** be appended to the surgical procedure codes.
- Procedure codes with modifier 55 appended will price at 15% of the allowable charge.

Clinical Information Requirements:

- Medical records are not required with the claim, but must be available upon request.
- Clinical information documented in the patient's records must support to use of this modifier.
- The portion of the global days the patient was seen by the provider must be indicated in the documentation.

Modifier 56 Usage

CPT4 Definition:

Modifier 56 - Preoperative Management Only

- Modifier 56 is reported when one physician performed the preoperative care and evaluation and another physician performed the surgical procedure. Modifier 56 is appended to the surgical code. The physician is paid a portion of the global package.
- Modifiers 56 **must only** be appended to the surgical procedure codes.
- Procedure codes with modifier 56 appended will price at 15% of the allowable charge.

Clinical Information Requirements:

- Medical records are not required with the claim, but must be available upon request.
- Clinical information documented in the patient's records must support to use of this modifier.
- The portion of the global days the patient was seen by the provider must be indicated in the documentation.

Modifier 57 Usage

CPT4 Definition:

Modifier 57 - Decision for Surgery

- The purpose of this modifier is to report a service that resulted in the initial decision to perform the surgery.
- Modifier 57 is appended to the appropriate level of E/M CPT code.
- Modifier 57 **cannot** be appended to any code other than an E/M code.

Clinical Information Requirements:

- Medical records are not required with the claim, but must be available upon request.
- Documentation must establish that the decision for surgery was made during a specific visit.

Modifier 58 Usage

CPT4 Definition:

Modifier 58 -Staged or related procedure or service by the same physician during the postoperative period

- The purpose of this modifier is to report the performance of a procedure or service during the postoperative period for one of the following circumstances:
 - planned or staged
 - more extensive than the original procedure
 - therapy following a surgical procedure
- This modifier is used to report a staged or related procedure by the same physician during the postoperative period of the first procedure.
- Modifier 58 is used **only** during the global surgical period for the original procedure.
- Modifier 58 **cannot** be reported when treatment of a problem requires return to the operating room.
- Modifier 58 **cannot** be used for staged procedures when the code description indicates "one or more visits or one or more sessions."

Clinical Information Requirements:

- Claims submitted with Modifier 58 that do not pass Correct Coding Initiative edits, will be accepted but not processed for benefits until medical documentation is received to support use of the modifier. You should submit the medical records using the Provider Correspondence Form.

Modifier 59 Usage

CPT4 Definition:

Modifier 59 - Procedural Service

- The purpose of this modifier is to identify procedures or services that are not usually reported together but appropriate under the circumstances. This may represent the following:
 - A different session or patient encounter
 - A different procedure or surgery
 - A different site or organ system
 - A separate incision or excision
 - A separate lesion
 - A separate injury (or area of injury in extensive injuries)
- These circumstances are not usually encountered or performed on the same day by the same individual.
- When another modifier already established modifier is appropriate, it should be used rather than modifier 59.
- Modifier 59 **cannot** be appended to an E/M service.

Clinical Information Requirements:

- Claim submitted with Modifier 59 that do not pass Correct Coding Initiative edits, will be accepted but not processed for benefits until medical documentation is received to support use of the modifier. You should submit the medical records using the Provider Correspondence Form.
- Documentation must be specific to the distinct procedure or service and clearly identified in the medical record.
- Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion or separate injury, etc.

Modifier 62 Usage

CPT4 Definition:

Modifier 62 - Two Surgeons

- The purpose of this modifier is to report when two surgeons work together as primary surgeons performing distinct part(s) of a procedure.
- Each surgeon **must** report his/her distinct operative work by adding the modifier 62 to the procedure code and any associated add-on codes(s) for that procedure as long as both surgeons continue to work together as primary surgeons.
- Each surgeon **must** report the co-surgery once using the same procedure code. If additional procedure(s), including add-on procedures(s) are performed during the same surgical session, separate code(s) may also be reported without the modifier 62 added.
- If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with the modifier 80 or 82 added, as appropriate.
- Multiple surgery reduction applies if more than one procedure is performed during the same operative session.
- Modifier 62 will price the procedure at 62.5% of the allowable charge, if a pre-set co-surgeon reimbursement agreement **has not been made** by the provider(s) and Blue Cross and Blue Shield of Mississippi. If a pre-set co-surgeon reimbursement agreement has been made, modifier 62 will be priced according to the terms outlined in the contract.

Clinical Information Requirement

- Medical records are required with the claim and must be made available upon request.

Modifier 63 Usage

CPT4 Definition:

Modifier 63 - Procedures Performed on Infants Less than 4kg

- The purpose of this modifier is to report procedures performed on neonates and infants up to a present body weight of 4kg may involve significantly increased complexity and physician work commonly associated with these patients.
- This modifier **must only** be appended to procedures/services listed in the 20000-69990 code services.
- Multiple surgery reduction applies if more than one procedure is performed during the same operative session.
- Modifier 63 will price the procedure at 120% of the allowable charge.

Clinical Information Requirement

- Medical records are not required with the claim, but must be available upon request.

Modifier 78 Usage

CPT4 Definition:

Modifier 78 - Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period

- The purpose of this modifier is to report a related procedure performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure) and requires use of the operating/procedure room.
- Modifier 78 **cannot** be used if a complication does not require use of the operating/procedure room.
- Modifier 78 may be used to report procedures performed on the same day (usually in emergency situations).

Clinical Information Requirements:

- Claim submitted with Modifier 78 that do not pass Correct Coding Initiative edits, will be accepted but not processed for benefits until medical documentation is received to support use of the modifier. You should submit the medical records using the Provider Correspondence Form.
- Documentation must include medical documentation of the complication requiring treatment.

Modifier 79 Usage

CPT4 Definition:

Modifier 79 - Unrelated procedure or service by the same physician during the postoperative period

- The purpose of this modifier is to report services during the postoperative period that are unrelated to the original procedure.
- The procedure must be performed by the same physician, and modifier 79 is appended to the procedure code.

Clinical Information Requirement

- Claim submitted with Modifier 79 that do not pass Correct Coding Initiative edits, will be accepted but not processed for benefits until medical documentation is received to support use of the modifier. You should submit the medical records using the [Provider Correspondence Form](#).
- Documentation must include a different diagnosis and support medical necessity.

Modifier 80 Usage

CPT4 Definition:

Modifier 80 - Assistant Surgeon

- The purpose of this modifier is to report services when one physician assists another physician during a surgical procedure.
- This modifier is not intended for use by non-physician providers (i.e., registered nurse first assistants (RNFA) with a CNOR certification in addition to our current providers; physician assistants (PA), certified registered nurse first assistants (CRNFA) and nurse practitioners (NP),, modifier AS **must** be used.
- Multiple surgery reduction applies if more than one procedure is performed during the same operative session
- The primary surgeon **cannot** append this modifier to the procedure code.
- If the procedure requires a co-surgeon, modifier 62 **must** be used.
- Modifier 80 will price the procedure at 20% of the allowable charge.

Clinical Information Requirement

- Medical records are not required with the claim, but must be available upon request.

Modifier 81 Usage

CPT4 Definition:

Modifier 81 - Minimum Assistant Surgeon

- The purpose of this modifier is to report services when a primary surgeon plan to perform a procedure alone, during the operation circumstances may arise that requires the services of an assistant surgeon for a relatively short time.
- This modifier is not intended to for use by non-physician and non-physician assistants who do not meet the payment criteria for payment, which includes surgical technicians.
- Multiple surgery reduction applies if more than one procedure is performed during the operative session.
- The primary surgeon **cannot** append this modifier to the procedure code.
- Modifier 81 will price the procedure at 20% of the allowable charge.

Clinical Information Requirement

- Medical records are required and must be made available upon request.

Modifier 82 Usage

CPT4 Definition:

Modifier 82 - Assistant Surgeon (When Qualified Resident Surgeon Not Available)

- The purpose of this modifier is to report services when an assistant at surgery is used in the event a qualified resident surgeon is unavailable.
- Multiple surgery reduction applies if more than one procedure is performed during the operative session.
- Modifier 82 will price the procedure at 20% of the allowable charge.

Clinical Information Requirement

- Medical records are not required with the claim, but must be available upon request.

HCPCS Modifiers RT and LT usage

HCPCS Modifiers RT/LT - Right side and left side

- The purpose of these modifiers is to identify procedures performed on the left or right side of the body.
- Modifiers LT and RT **do not** indicate bilateral procedures.
- Blue Cross & Blue Shield of Mississippi will accept modifiers RT and LT be used with non-surgical codes such as radiological procedures, procedures in the medicine section of the CPT manual, prosthetic and orthoptic devices, etc. as appropriate.

Clinical Information Requirement

- Claim submitted with Modifiers RT/LT that do not pass Correct Coding Initiative edits, will be accepted but not processed for benefits until medical documentation is received to support use of the modifier. You should submit the medical records using the Provider Correspondence Form.
- This information must be submitted with the claim if two LTs and/or two RTs are submitted and used more than once on the same claim for procedure codes normally considered as inclusive procedures.

Modifier AS Usage

HCPCS Definition:

Modifier AS - Non-physician as Assistant Surgeons

- Blue Cross & Blue Shield of Mississippi (BCBSMS) will provide benefits for assistant at surgery services when rendered by registered nurse first assistants (RNFA) with a CNOR certification in addition to our current providers; physician assistants (PA), certified registered nurse first assistants (CRNFA) and nurse practitioners (NP).
- Modifier AS will price the procedure at 10% of the allowable charge for the primary, add-on (Appendix D of the CPT manual), and modifier -51 exempt procedures (Appendix E of the CPT manual).
- Secondary and bilateral procedures will be reimbursed at 5% of the allowable charge for the surgical procedure.

Clinical Information Requirement

- Medical records are not required but must be made available upon request.
- For more information concerning Modifier AS, please refer to our Coding Policy, “Nurse & Physician Assistants (PA) as Surgical Assistants”.

Modifier GG Usage

HCPCS Definition:

Modifier GG - Screening and Diagnostic Mammography on the Same Day

- The purpose of this modifier is to report when a screening mammogram and a diagnostic mammogram were performed on the same day.
- Modifier GG will price the procedure at 120% of the allowable charge.

Clinical Information Requirement

- Medical records are not required with the claim, but must be available upon request.