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PAYMENT POLICY ID NUMBER: 10-011

Original Effective Date: 05/14/10

Revised: 05/31/12

Modifier Reference

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISSUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO BCBSF MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OR THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY.

DESCRIPTION:

A modifier provides a physician with the means to indicate that a service/procedure is altered by some specific circumstance, but not changed in its definition or code. By modifying the meaning of a service, modifiers may be used in some instances when additional information is needed for proper payment of claims. Valid modifiers and their descriptions can be found in the most current CPT and HCPCS coding books.

Modifiers may be used to indicate that:

- A service or procedure has both a professional and technical component.
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure has been increased or reduced.
- Only part of a service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.

The modifiers listed below represent modifiers that are referenced in one of Florida Blue's payment policies and this guide should act as a crosswalk to the referenced policies. In addition, there are some modifiers included in this policy that do not reference a policy. These modifiers represent commonly billed modifiers. It is not an all-inclusive list of CPT and HCPCS modifiers.

REIMBURSEMENT INFORMATION:

Florida Blue processes claims using only the first two modifiers submitted. While up to four modifiers are accepted, claims are processed using only modifiers in the first and second position. Therefore, modifiers affecting reimbursement should be submitted in the first and second position on paper and electronic claims.

BILLING/CODING INFORMATION:

Modifier	Description	Billing/Coding Standards	Refer to Payment Policy
22	**Increased Procedural Services:** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code.	This modifier should not be appended to an E/M service.	Robotic Assisted Surgery
24	**Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period:** The physician may need to indicate that an E/M service was performed during a postoperative period for a reason unrelated to the original procedure. Clinical records may be required to establish appropriate use of modifier 24.		Global Surgery Package
25	**Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service:** It may be necessary to indicate that on the 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 other service provided or beyond the usual preoperative care associated with the procedure that was performed.	This modifier should be used with E/M codes only and not appended to the surgical procedure code.	Global Surgery Package
26	**Professional Component:** Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.		
47	**Anesthesia by Surgeon:** Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service.	This modifier would not be used as a modifier for the anesthesia procedures.	Anesthesia Services
50	**Bilateral Procedure:** Unless otherwise identified in the listings, bilateral procedures	BCBSF requires bilateral procedures be	Bilateral Procedures, Multiple Surgical

Modifier	Description	Billing/Coding Standards	Refer to Payment Policy
	that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code.	reported as two separate claim lines. On one of the two lines, modifier 50 may be used, with the other line reported without a modifier.	Procedure Reduction (Including Multiple Endoscopic Procedure Reduction)
51	**Multiple Procedures:** When multiple procedures are performed, other than E/M services, physical medicine and rehabilitation services, or provision of supplies, are performed at the same session by the same provider, the primary procedure or service may be identified by appending modifier 51 to the additional procedure or service code.	This modifier should not be appended to designated add-on codes.	Multiple Surgical Procedure Reduction (Including Multiple Endoscopic Procedure Reduction)
52	**Reduced Services:** 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 number and the addition of modifier 52, signifying that the service is reduced.		
53	**Discontinued Procedure:** 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 circumstance may be reported by adding modifier 53 tot eh code reported by the physician for the discontinued procedure.		
54	**Split Care Only:** When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.		Split Surgical Package
55	**Postoperative Management Only:** When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual		Split Surgical Package

Modifier	Description	Billing/Coding Standards	Refer to Payment Policy
	procedure number.		
56	**Preoperative Management Only:** When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.		Split Surgical Package
57	**Decision for Surgery:** An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.	This modifier is used only with an E/M service.	Global Surgery Package
58	**Staged or Related Procedure or Service by the Same Physician During the Postoperative Period:** It may be necessary to indicate that the performance of a procedure or service during the postoperative period was planned or anticipated; more extensive than the original procedure; or for therapy following a surgical procedure.		Global Surgery Package
62	**Two Surgeons:** When two surgeons work together as primary surgeons performing distinct parts of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on codes for that procedure as long as both surgeons continue to work together as primary surgeons.		Co-Surgeons (Two Surgeons) and Surgical Team
66	**Surgical Team:** Under some circumstances, highly complex procedures are carried out under the “surgical team” concept. Such circumstances may be identified by each participating physician with the addition of modifier 66 to the basic procedure number used for reporting services.		Co-Surgeons (Two Surgeons) and Surgical Team
76	**Repeat Procedure or Service by Same Physician:** It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service.		

Modifier	Description	Billing/Coding Standards	Refer to Payment Policy
78	**Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period:** It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure. When this procedure is related to the first and requires the use of an operating or procedure room, it may be reported by adding modifier 78 to the related procedure.		Global Surgery Package
79	**Unrelated Procedure or Service by the Same Physician During the Postoperative Period:** The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79.		Global Surgery Package
80	**Assistant Surgeon:** Surgical assistant services may be identified by adding modifier 80 to the usual procedure numbers.		Surgical Assistant
81	**Minimum Assistant Surgeon:** Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.		Surgical Assistant
82	**Assistant Surgeon (when qualified resident surgeon not available):** The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number.		Surgical Assistant
AA	**Anesthesia Services performed personally by anesthesiologist**	Time based anesthesia services require an anesthesia modifier.	Anesthesia Services
AD	**Medical supervision by a physician: more than 4 concurrent anesthesia procedures**	This modifier is not recognized by BCBSF for reimbursement except for Medicare Advantage products.	Anesthesia Services
AS	**Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery**		Surgical Assistant

Modifier	Description	Billing/Coding Standards	Refer to Payment Policy
G8	**Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure**		Anesthesia Services
G9	**Monitored anesthesia care for patient who has history of severe cardiopulmonary condition**		Anesthesia Services
LT	**Left Side:** Used to identify procedures performed on the left side of the body.		Bilateral Procedures
P1	**Physical Status Modifier:** A normal healthy patient.	Additional reimbursement is not provided for the physical status (P) modifiers.	Anesthesia Services
P2	**Physical Status Modifier:** A patient with mild systemic disease.	Additional reimbursement is not provided for the physical status (P) modifiers.	Anesthesia Services
P3	**Physical Status Modifier:** A patient with severe systemic disease.	Additional reimbursement is not provided for the physical status (P) modifiers.	Anesthesia Services
P4	**Physical Status Modifier:** A patient with severe systemic disease that is a constant threat to life.	Additional reimbursement is not provided for the physical status (P) modifiers.	Anesthesia Services
P5	**Physical Status Modifier:** A moribund patient who is not expected to survive without the operation.	Additional reimbursement is not provided for the physical status (P) modifiers.	Anesthesia Services
P6	**Physical Status Modifier:** A declared brain-dead patient whose organs are being removed for donor purposes.	Additional reimbursement is not provided for the physical status (P) modifiers.	Anesthesia Services
PT	**Colorectal cancer screening test; converted to diagnostic test or other procedure.**	Used as a determinant to pay claims as preventative.	
QK	**Medical direction if 2,3, or 4 concurrent anesthesia procedures involving**	Time based anesthesia services require an	Anesthesia Services

Modifier	Description	Billing/Coding Standards	Refer to Payment Policy
	qualified individuals	anesthesia modifier.	
QS	**Monitored anesthesia care services**	Only one QS service per day will be allowed.	Anesthesia Services
QX	**CRNA service: with medical direction by a physician**	Time based anesthesia services require an anesthesia modifier.	Anesthesia Services
QY	**Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist**	Time based anesthesia services require an anesthesia modifier.	Anesthesia Services
QZ	**CRNA service: without medical direction by a physician**	Time based anesthesia services require an anesthesia modifier.	Anesthesia Services
RT	**Right Side:** Used to identify procedures performed on the right side of the body.		Bilateral Procedures
TC	**Technical Component:** Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.		Multiple Imaging Reduction

COMMITTEE APPROVAL:

This Payment Policy was approved by the Florida Blue Payment Policy Committee on 05/14/10.

GUIDELINE UPDATE INFORMATION:

05/14/10	New Payment Policy
	Payment Policy titles were updated to reflect revised titles.
05/31/12	Revised – Changed name from BCBSF to Florida Blue

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