Modifier Guidelines

Policy Number: PG0011
Last Review: 12/12/2017

PARAMOUNT

ADVANTAGE | ELITE | HMO
INDIVIDUAL MARKETPLACE |
PROMEDICA MEDICARE
PLAN | PPO

GUIDELINES

This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder contract. Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards. This guideline is solely for explaining correct procedure reporting and does not imply coverage and reimbursement.

SCOPE

X Professional
_ Facility

DESCRIPTION

Modifiers are used to enhance the description of a specific CPT/HCPCS code used to report a service. There are two levels of modifiers:

- Level I: CPT modifiers are two numeric digits and are developed by the American Medical Association (AMA).
- Level II: HCPCS modifiers are two alpha characters (AA through VP) and are developed by the Centers for Medicare & Medicaid Services (CMS).

A modifier enables a provider to report that a service or procedure has been altered by some specific circumstance, when that circumstance is not defined by a different code. Certain modifiers are used for informational purposes only, and do not affect payment amounts. The use of modifiers eliminates the need for separate procedure listings that may describe the modifying circumstances.

Modifiers may be used to indicate that:

- A service or procedure has a professional or 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.
- An add-on or additional service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.
- A service or procedure was performed on a specific site.

POLICY

CPT modifiers that may affect claims payment per guidelines below: 22, 24, 25, 26, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 62, 63, 66, 73, 74, 78, 79, 80, 81, 82, and 92.

HCPCS modifiers that may affect claims payment per guidelines below: CT, E1-E4, FA-F9, TA-T9, RT, LT, RC, LC, LD, RI, LM, AA, QK, AD, QY, QX, QZ, QS, G8, G9, QE, QF, QG, QH, RR, MS, U1, AS, GA, KX, P1-P6, SG, and TC.

For modifier 77 refer to PG0006 X-ray Interpretation for guidelines.
For modifier PT refer to PG0065 Colorectal Cancer Screening for guidelines.
For modifier TH refer to PG0083 Obstetrical Treatment Services for guidelines.

For modifiers GQ, GT, UA refer to PG0142 Telehealth Services for guidelines.
For modifier AT refer to PG0150 Chiropractic Services & Spinal Manipulation for guidelines.
For modifiers Q7, Q8, Q9 refer to PG0246 Routine Foot Care for guidelines.

COVERAGE CRITERIA

HMO, PPO, Individual Marketplace, Elite/ProMedica Medicare Plan, Advantage

Claims with inappropriate modifier to procedure code combinations will be denied. Claims must be resubmitted with correct modifier for payment. Please see guidelines below.

CODING/BILLING INFORMATION

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

MODIFIER	GUIDELINES
22 Increased Procedural Services	• Modifier 22 should only be used when the physician's technical skill involves significantly increased work, time, and complexity of the procedure performed. • Obesity or a change in surgical methods (scope to open) is not considered criteria to support additional reimbursement. • This modifier is not appended to evaluation and management (E/M) services (99201-99499). • Medical records are required with the claim for medical review. The documentation should support, in detail, that the service provided involved significantly increased work, time, and complexity of the procedure performed to receive additional compensation.
24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period	• Modifier 24 is used to report an evaluation and management service performed during a postoperative period by the same physician or same group practice for reasons unrelated to the original procedure. • Append modifier 24 to the E/M procedure code. • Use on an unrelated E/M service beginning the day after a procedure, when the E/M is performed by the same physician* during the 10 or 90 day post-operative period. • Use modifier 24 on the E/M if documentation indicates the service was exclusively for treatment of the underlying condition and not for post-operative care. • Use modifier 24 on the E/M code when the same physician* is managing immunosuppressant therapy during the post-operative period of a transplant. • Use modifier 24 on the E/M code when the same physician* is managing chemotherapy during the post-operative period of a procedure. • When the same physician* provides unrelated critical care during the post-operative period. • When applying this modifier, the physician/surgeon must provide clear documentation to identify that the E/M service is unrelated to the surgical procedure. Generally, the diagnosis code would be different from the diagnosis for which the procedure was performed. Medical records are not required with the claim, but must be available upon request. * Note: when two physicians from the same specialty, same practice, see a patient on the same date they must bill and be paid as though they were a single physician; per CMS Correct Coding Guidelines.
25 Significant, Separately Identifiable	• Modifier 25 is used to indicate that the E/M service was significant and separately identifiable from a minor procedure performed on the same day. • Modifier 25 will not be recognized with a minimal office visit for an established patient (99211) performed on the same date as a preventive medicine visit (99391-99397).

Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service.	• E/M services performed the same day as a 0 or 10-day global medical or surgical service will be denied as included in the global surgical package, unless the service was significant and separately identifiable from the minor procedure and is indicated with modifier 25. • 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. • Medical records are not required with the claim, but must be available upon request.
26 **Professional Component**	• Professional Component refers to certain procedures that are a combination of a physician component and a technical component. Using modifier 26 identifies the physician's component. • Use modifier 26 to bill for only the professional component portion of a test • Use modifier 26 to report the physician's interpretation of a test • Services billed with modifier 26 will be denied if another provider has been reimbursed for global services.
50 **Bilateral 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 and/or bilateral. • Bilateral modifiers must be appended to the appropriate unilateral code as a one-line entry on the claim form indicating that the procedure was performed bilaterally. The unit box on the claim form should indicate that “1” unit of service was provided, i.e., one procedure was performed bilaterally. • Medical records are not required with the claim, but must be available upon request.

51
Multiple Procedure
	• Modifier 51 designates multiple procedures that are performed at the same session by the same provider, other than E/M services, physical medicine and rehabilitation services, or provision of supplies.
	• Paramount considers the surgical procedure with the highest allowable amount the primary (first) procedure.
	• 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.
	• Paramount 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
	  ○ Codes that are surgical procedures
	• Medical records are not required with the claim, but must be available upon request.

52 **Reduced Services**	• Modifier 52 indicates that a service or procedure has been partially reduced or eliminated at the physician’s discretion. • 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. • 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. Medical records are not required with the claim, but must be available upon request.
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 a service or procedure that 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. • 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. Medical records are not required with the claim, but must be available upon request.
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 must only be appended to the surgical procedure codes. • The physician is paid a portion of the global package. • Clinical information documented in the patient's records must support to use of this modifier. Medical records are not required with the claim, but must be available upon request.
55 Postoperative Management Only	• Modifier 55 is reported when one physician performed the postoperative management only; another physician performed the surgical procedure. • Modifier 55 must only be appended to the surgical procedure codes. • The physician is paid a portion of the global package. • 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. Medical records are not required with the claim, but must be available upon request.
56 Preoperative Management Only	• Modifier 56 is reported when one physician performed the preoperative care and evaluation only; another physician performed the surgical procedure. • Modifier 56 must only be appended to the surgical procedure codes. • The physician is paid a portion of the global package. • 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. Medical records are not required with the claim, but must be available upon request.
57 Decision for Surgery	• Modifier 57 is an E/M service that results in the initial decision to perform surgery. It is intended to report that the decision to perform major surgery occurred on the day of or day prior to, a major (90-day global) surgical procedure. • Modifier 57 is appended to the appropriate level of E/M code. Modifier 57 should not be appended to an E/M service associated with a major surgery that has been planned in advance. Some categories of planned surgery would be inconsistent with a decision

	for surgery occurring the day of, or day prior to, the procedure, except when performed in the setting of an office or inpatient consultation, or emergency department. Categories of these planned surgeries include, but are not limited to: ○ spine surgery (excluding fractures and dislocations) ○ arthroplasty (total, partial, revision) ○ congenital/deformity procedures ○ chronic/sub-acute conditions ○ transplant procedures • E/M services with modifier 57 for these categories of planned surgery will be denied when billed outside the consultative and emergency settings noted above. • E/M services performed the same day as a 90-day global medical or surgical service will be denied as included in the global surgical package, unless the service consisted of a decision for surgery and is indicated with modifier 57. • Modifier 57 cannot be appended to any code other than an E/M code. • Documentation must establish that the decision for surgery was made during a specific visit. Medical records are not required with the claim, but must be available upon request.
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 • Modifier 58 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." • Medical records are not required with the claim, but must be available upon request.
59 **Distinct 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 already established modifier is appropriate, it should be used rather than modifier 59. • Modifier 59 cannot be appended to an E/M service. • 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. Medical records are not required with the claim, but must be available upon request.
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 their 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. • Medical record documentation should show the services of each provider to support co-surgery. When each surgeon is performing part(s) of the same surgery simultaneously with the same or different specialties, medical record documentation should show the services of each surgeon and the medical necessity of two surgeons. Medical records are not required with the claim, but must be available upon request.
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. • Medical records are not required with the claim, but must be available upon request.

66
Team Surgery
	• If a team of surgeons (more than two surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier 66.
	• Procedures that are minor, non-surgical, or that are not of sufficient complexity to require multiple physicians of different specialties and other highly skilled personnel and equipment, do not satisfy the definition of team surgery.
	• Medicare Physician Fee Schedule Database (MPFSDB) assigns payment indicators for which payment adjustment rules for team surgeon procedures. The following indicators identify services for which team surgeons may be paid:
	  ○ 0: Team surgeons not permitted for this procedure.
	  ○ 1: Team surgeons may be paid if supporting documentation is supplied to establish medical necessity of a team. Paid by report.
	  ○ 2: Team surgeons may be paid. Paid by report.
	• Global surgery rules apply to each of the physicians participating in a team surgery.
	• While Medicare allows documentation review of team surgery services with status indicators of 1 and 2, this does not indicate reimbursement. Documentation guidelines must be applied, as well as the provider and provider specialty guidelines determined by Medicare. In addition, some of the approved services fall into contractual agreements (i.e. transplants) in which modifier 66 documentation review does not apply.

73 **Discontinued Outpatient Procedure Prior to Anesthesia Administration**	• Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided and being taken to the room where the procedure is to be performed,) but prior to the administration of the anesthesia. • Do not use this modifier for the elective cancellation of a procedure. • Do not use modifier 73 if the surgeon cancels or postpones the scheduled surgery because of a patient complaint such as a cold or flu upon intake. • The physician should not use this modifier. This is only appropriate for use by a facility.

74 Discontinued Outpatient Procedure After Anesthesia Administration	• Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia or after the procedure was started (incision made, intubation started, scope inserted.) • Paramount will make the full payment of the surgical procedure if a medical complication arises which causes the procedure to be terminated • The physician should not use this modifier. This is only appropriate for use by a facility. • The operative report and documentation should include ALL of the following: o Reason for termination of the surgery o Services actually performed o Supplies actually provided o Services not performed that would have been performed if surgery had not been terminated o Supplies not provided that would have been provided if the surgery had not been terminated o Time actually spent is each stage, e.g., pre-operative, operative, and post-operative, o Time that would have been spent in each of these stages if the surgery had not been terminated, o HCPCS code for procedure had the surgery been performed
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). • Documentation must include medical documentation of the complication requiring treatment. Medical records are not required with the claim, but must be available upon request.
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. • Documentation must include a different diagnosis and support medical necessity. Medical records are not required with the claim, but must be available upon request.
80 Assistant Surgeon	• The purpose of this modifier is to report services when one physician assists another physician during a surgical procedure. • Modifier 80 is not intended for use by non-physician providers. • The American College of Surgeons (ACS) medical criteria designation guidelines are applied to all product lines and not the CMS designation guidelines. • All services, if an assistant surgeon is allowed, are subject to multiple surgical reductions and bundling software edits. • Medical records are not required with the claim, but must be available upon request.
81 Minimum Assistant Surgeon	• The purpose of this modifier is to report services when a primary surgeon plans to perform a procedure alone and during the operation circumstances arise that requires the services of an assistant surgeon for a relatively short time. • Modifier 81 is not intended for use by non-physician and non-physician assistants who do not meet the payment criteria for payment, which includes surgical technicians.

	• The ACS medical criteria designation guidelines are applied to all product lines and not the CMS designation guidelines. • All services, if an assistant surgeon is allowed, are subject to multiple surgical reductions and bundling software edits. • Medical records are not required with the claim, but must be available upon request.
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. • The ACS medical criteria designation guidelines are applied to all product lines and not the CMS designation guidelines. • All services, if an assistant surgeon is allowed, are subject to multiple surgical reductions and bundling software edits. • Medical records are not required with the claim, but must be available upon request.
92 **Alternative Laboratory Platform Testing**	• When a laboratory test is performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable, analytical chamber. • The test does not require permanent dedicated space. • The test is designed to be carried or transported to the vicinity of the patient for immediate testing at that site. • Modifier 92 may only be appended to procedures 86701-86703, and 87389 (HIV testing) per CPT verbiage. • There is no reimbursement differential when this modifier is appended, but is used for identification purposes.
Anatomical Modifiers **E1-E4 (Eyes)** **FA-F9 (Fingers)** **TA-T9 (Toes)** **RC, LC, LD, RI, LM (coronary arteries)** **RT, LT**	• Anatomic-specific modifiers designate the area or part of the body on which the procedure is performed. These modifiers allow automated, accurate payment of claims. • There are specific anatomic modifiers E1-E4 (Eyes), FA-F9 (Fingers), and TA-T9 (Toes), and RC, LC, LD, RI, LM (coronary arteries). Modifiers RT and LT designate right and left, respectively. • Modifiers LT and RT do not indicate bilateral procedures. Modifier 50 is used when bilateral procedures are performed on both sides at the same operative session. • Anatomical modifiers E1-E4 (Eyes), FA-F9 (Fingers), and TA-T9 (Toes) have a maximum allowable of one unit per anatomical site for a given date of service. Any service billed with an anatomical modifier for more than one unit of service will be adjusted accordingly. • 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.

Anesthesia Documentation Modifiers
AA, QK, AD, QY, QX, QZ
	• Documentation modifiers direct prompt and correct payment of the anesthesia claims submitted.
	• Anesthesia documentation modifiers that MUST be billed in the first modifier field:
	  ○ AA: Anesthesia services performed personally by an anesthesiologist.
	  ○ QK: Medical direction by a physician of two, three, or four concurrent anesthesia procedures.
	  ○ AD: Medically supervised by a physician, more than four concurrent anesthesia procedures.
	  ○ QY: Medical direction of one CRNA/AA (Anesthesiologist's Assistant) by an anesthesiologist.
	  ○ QX: CRNA/AA (Anesthesiologist's Assistant) service with medical direction by a physician.
	  ○ QZ: CRNA service without medical direction by a physician.
	• If a QS modifier applies, it must be in the second modifier field.

	• Processing delays and denials may occur for claims submitted without the modifiers in the correct position.

Monitored Anesthesia Care QS, G8, G9	• Monitored anesthesia care (MAC) is defined as light, moderate, or deep sedation where the provider must be prepared and qualified to convert to general anesthesia.
	• Used only to identify MAC services in the inpatient and outpatient setting.
	• Append to an anesthesia procedure code only.
	• Append after the pricing anesthesia modifier.
	• Report the actual anesthesia time on the claim.
	• MAC modifiers that MUST be billed in the second modifier field:
	  ○ QS: MAC services (can be billed by a CRNA, AA, or physician). It must be used with the anesthesia service provided if it is delivered.
	  ○ G8: Used to indicate certain deep, complex, complicated, or markedly invasive surgical procedures. This modifier is to be applied to the following anesthesia codes only: 00100, 00300, 00400, 00160, 00532 and 00920
	  ○ G9: Represents a history of severe cardiopulmonary disease, and should be utilized whenever the physician feels the need for MAC due to a history of advanced cardiopulmonary disease. The documentation of this clinical decision making process and the need for additional monitoring must be clearly documented in the medical record

Oxygen Modifiers QE, QF, QG, QH, RR, MS, U1	• Fee schedule payments for stationary oxygen system rentals are all-inclusive, and represent a monthly allowance per member. Accordingly, a supplier must bill on a monthly basis for stationary oxygen equipment and contents furnished during a rental month.
	• A portable equipment add-on is also payable when portable oxygen is prescribed, and it is determined to be medically necessary in accordance with Medicare coverage requirements. The portable add-on must be reported in order to be paid. The monthly payment amount for stationary oxygen is subject to adjustment depending on the amount of oxygen prescribed liters per minute (LPM), and whether or not portable oxygen is also prescribed.
	• Claims must indicate the appropriate modifier described below if applicable (one month of service equals one unit).
	  ○ QE: Prescribed amount of oxygen is less than 1 LPM
	  ○ QF: Prescribed amount of oxygen is greater than 4 LPM and portable oxygen is also prescribed
	  ○ QG: Prescribed amount of oxygen is greater than 4 LPM and portable oxygen is not prescribed
	  ○ QH: Oxygen conserving device is being used with an oxygen delivery system
	  ○ RR: Rental equipment
	  ○ MS: Maintenance and Service
	  ○ U1: Oxygen services are provided via the use of a stationary oxygen concentrator to a consumer in a private residence. (Only utilized by Advantage)

AS Physician Assistant Services for Assistant Surgeon	• Designates that services were provided by a physician assistant, nurse practitioner or nurse midwife for an assistant at surgery. • The ACS medical criteria designation guidelines are applied to all product lines and not the CMS designation guidelines. • All services, if an assistant surgeon is allowed, are subject to multiple surgical reductions and bundling software edits. • Medical records are not required with the claim, but must be available upon request.
CT Computed	• Effective January 1, 2016, Outpatient Prospective Payment System (OPPS) providers must report this modifier on computed tomography (CT) services furnished using

Tomography Services	equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013. • Required on claims for CT scans described by HCPCS codes 70450 - 70498; 71250 - 71275; 72125 - 72133; 72191 - 72194; 73200 - 73206; 73700 - 73706; 74150 - 74178; 74261 - 74263; and 75571 - 75574. • This modifier should not be reported with CT scans not listed above.
GA **Waiver of Liability on File for Non-Covered Services**	• Modifier GA indicates that the services being performed are not considered medically necessary and a signed consent has been obtained from the member in order to provide the service/product to the member. The member assumes all financial responsibility for the service because of their personal prior approval on file with the provider. o HMO, PPO, and Elite ProMedica Medicare Plan members would consider this an Advanced Beneficiary Notice (ABN) o Advantage members would consider this consent a waiver of financial liability • The ABN or financial waiver of liability is defined as a written notice from the physician/supplier before a service/product is provided that is deemed to be non-covered, not reasonable, and not medically necessary. • The purpose is to allow the member to make an informed consumer decision as to whether they want to assume the additional out-of-pocket expenses, prior to obtaining the service/product. o Medicare has specific rules surrounding their use of an ABN. o Medicaid has specific rules surrounding their use of a financial waiver of liability. • Modifier GA may <u>never</u> be used if the consent or ABN was obtained after the service/product was provided to the member. • If a signed consent is not obtained, the provider will assume all financial responsibility for the non-covered service/product rendered.
KX **Requirements Specified in the Medical Policy have been Met**	• When additional documentation is available to support the medical necessary service under a medical policy. • Medicare expects the use of modifier KX to enable the durable medical equipment Medicare administrative contractor (DME MAC) to perform automated medical review of claims. • Modifier KX serves as an attestation by the supplier that the requirements for its use that are defined in the particular local coverage determination (LCD) are true for that specific beneficiary. It must not be added indiscriminately just “because it is needed to get the claim paid.” • A denial will be the provider's liability unless the provider has had the member sign an ABN of non-coverage explaining why the item will be likely denied. • While the application of modifier KX is not required for claim submission and reimbursement, all the documentation requirements established by Medicare are still expected to be followed. • Currently, many of these items require prior authorization. A provider must refer to the Paramount prior authorization list and specific medical policy in reference to specific items.
P1-P6 **Anesthesia Physical Status**	• Append to anesthesia service/procedure codes • The modifiers are informational only and do not affect payment: o P1: A normal healthy patient o P2: A patient with mild systemic disease o P3: A patient with severe systemic disease o P4: A patient with severe systemic disease that is a constant threat to life o P5: A moribund patient who is not expected to survive without the operation

	○ P6: A declared brain-dead patient whose organs are being removed for donor purposes
SG Ambulatory Surgery Center	• In order to identify services performed by an ambulatory surgical center (ASC), modifier SG is appended to each procedure reported in the first modifier field. This not only identifies the services, but also directs the fee schedule to the correct assigned surgical center grouper or payment rate. • While CMS no longer requires the application of this modifier, it is still considered a HIPAA correct modifier, and may still be applied to claims for processing. • CMS and the state of Ohio have a list of approved procedures that may be performed within the surgery center setting. Each of these procedures is assigned a grouper level with a specific fee. Each year this list is reviewed, and approved procedures are assigned. The current procedures may be reassigned to different grouper levels. Each of these services is identified by modifier SG in the first modifier field. It is mandatory that this modifier be placed in the first modifier field by the ASC. • Other reporting modifiers such as modifier RT and LT may be reported in the other modifier fields. It is recommended that an ASC not utilize modifier 50. While this is an approved ASC modifier, this will not allow the correct reimbursement when the procedure is the secondary service. It is recommended the ASC report bilateral services on two separate lines in order to receive the correct reimbursement.
TC Technical Component	• Modifier TC designates the technical component of a service. When the technical component is separately reportable, the service may be identified by appending modifier TC to the procedure code. • Services billed with modifier TC will be denied if another provider has been reimbursed for global services. • Services will be denied if a physician bills only the modifier TC component for a radiology service in their office. • Technical services provided in an ASC are not covered as a separate charge from the facility fee.

REVISION HISTORY EXPLANATION
ORIGINAL EFFECTIVE DATE: 10/30/2005
11/01/06: No change
12/01/07: No change
02/15/09: Updated verbiage
02/01/10: Updated
10/13/15: Title changed from Co-Surgeon to Modifier Guidelines. Combined 25 modifier medical policies. Added CPT Modifiers: 22, 24, 25, 26, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 63, 66, 73, 74, 78, 79, 80, 81, 82, and 92. Added HCPCS Modifiers: E1-E4, FA-F9, TA-T9, RT, LT, RC, LC, LD, RI, LM, AA, QK, AD, QY, QX, QZ, QS, G8, G9, QE, QF, QG, QH, RR, MS, U1, AS, GA, KX, P1-P6, SG, and TC. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.
12/12/17: Added CT modifier. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.
12/14/2020: Medical policy placed on the new Paramount Medical Policy Format

REFERENCES/RESOURCES
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services
Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
Industry Standard Review
Hayes, Inc.