EFFECTIVE DATE: 11|01|2023
POLICY LAST UPDATED: 06|07|2023

OVERVIEW

This Policy provides an overview of coding and payment guidelines as they pertain to claims submitted to Blue Cross & Blue Shield of Rhode Island (BCBSRI). These guidelines follow correct coding guidelines such as National and Regional Centers for Medicare and Medicaid Services (CMS) (including DMEMAC), CMS Claims Processing Manual, AMA guidelines, knowledge of anatomy, and the standards of medical practice. This policy is applicable for Medicare Advantage plans and Commercial Products.

PRIOR AUTHORIZATION

Not applicable

POLICY STATEMENT

Unless specified in a specific payment policy, BCBSRI follows correct coding and payment guidelines published by National and Regional CMS (including DMEMAC) and other correct coding national standards such as Current Procedural Terminology (CPT).

The following are examples of the most common coding and payment guidelines.

National Correct Coding Initiative (NCCI)

Blue Cross & Blue Shield of Rhode Island follows the National Correct Coding Initiative (NCCI) for physician and hospital outpatient claims.

NCCI are edits based upon code pairs. The edits are in place to prevent codes that should not be reported together from being reported and paid. Usually, one of the two codes of the pair is a service already included in the other procedure and not reported separately when correctly coding. In some cases, the services are mutually exclusive, i.e., the procedures would not be performed concurrently for clinical reasons.

NCCI edits are of two types:
1) There are "0" indicator edits, which are never correctly reported together
2) There are "1" indicator edits, which may be overridden by a modifier (typically modifier 59 or a digit modifier)

The following list of modifiers will be considered exception modifiers and the CCI Edit rules will be applied based on the modifier indicator flag that is in the CMS File:

- Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
- Global surgery modifiers: 24, 25, 57, 58, 78, 79
- Other modifiers: 27, 59, 91, XE, XS, XP, XU

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

Bundled Services for Outpatient Hospital

BCBSRI follows the Centers for Medicare and Medicaid (CMS) Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule for all codes that are covered. Codes with a status indicator of "N" on Addendum B are set up in our claims processing system as covered but not separately reimbursed (bundled) as CMS considers payment packaged into payment for other services. Updates are posted quarterly to the CMS OPPS website by CMS. BCBSRI updates codes considered packaged into APC rates on a quarterly basis based upon the CMS fee schedule.

https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/HospitalOutpatientpps/Addendum-A-and-Addendum-B-Updates.html

Note: Drugs that are billed with surgical procedures are bundled in the payment for the procedure. Exception: drugs billed with Chemodenervation services (code range 64600 through 64681) will be separately reimbursed.

Physician Fee Schedule
BCBSRI follows CMS Physician Fee Schedule (PFS) Relative Value Units (RVU) for details relating to

1) Global period
2) Assistant Surgeon
3) Two Surgeons (Co-Surgery)
4) Bilateral Surgery, and
5) Multiple Procedure Reductions status

The Medicare Physician Fee Schedule Relative Value Unit files can be found on the CMS Physician Fee Schedule website (currently labeled PPRRVUxx.xlsx) at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

1. Global Period
All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, or 090 days. If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. BCBSRI follows the surgical global period as designated by CMS on the Relative Value Units (RVU) files.

2. Assistant Surgeon (Modifiers 80, 81, AS)
When there is an assistant surgeon, the surgeon of record is listed as the primary surgeon. The surgeon of record is responsible for identifying the presence of the assistant surgeon and the work performed. In this situation, the assistant surgeon does not dictate an operative note. An MD, DO, PA, NP, CNS or RFNA serving as the assistant surgeon will report the CPT codes for those procedures.

The primary surgeon would report the procedures without a modifier and at their full fee. The assistant would append the appropriate assistant modifiers and at a reduced fee. The following modifiers should be used:

- Modifier 80: Assistant surgeon (MD or DO) who assisted on the majority of the case
- Modifier 81: Assistant surgeon (MD or DO) who assisted on less than the majority of the case available
- AS Modifier: Medicare modifier for a PA, NP, CNS or RFNA who is an assistant at surgery

Assistant Surgeon Payment Rules
BCBSRI uses the assistance surgeon indicators on the Medicare Physician Fee Schedule (PFS RVU file) as a guideline to determine if we will pay for an assistant surgeon. The indicators are 0, 1, 2, and 9.

BCBSRI will only pay for an assistant surgeon for those procedures with an indicator 2 (assistant surgeon may be paid). Participating physicians may not require members to pay for an assistant surgeon (indicator 0, 1 or 9), even if the members accept responsibility to do so, as this is charging outside of the approved amount.

These are not medical necessity determinations and are not reviewed for medical necessity if appealed. The payment determination is a contractual payment policy.

3. Co-Surgeons (Modifier 62)
Co-surgery means that two surgeons, typically each in a different specialty, are performing distinct separate parts of the same procedure. This most frequently occurs when one surgeon performs the approach, and the other surgeon performs the definitive procedure. For both surgeons to receive appropriate reimbursement, they must not be assisting each other, but performing distinct and separate parts of the same procedure.

If surgeons of different specialties are each performing a different procedure with specific CPT codes, neither co-surgery nor multiple surgery rules apply, even if performed through the same incision.

In certain instances, co-surgeons may be of the same specialty. In such cases, for services with a "1" or "2" indicator, Medicare Part B may pay for co-surgeons where the documentation justifies the medical necessity for two surgeons without regard to the two-specialty requirement.

The co-surgeon modifier 62 should be appended to only one primary procedure code and its associated add-on codes. If the second surgeon continues to assist on the case, he or she becomes the assistant surgeon; modifier 81 or 82 should be used in this case.

When two surgeons are reporting services as co-surgeons, two distinct operative notes are required. The operative notes should not overlap because this negates the concept of co-surgery and will drive the use of the appropriate assistant versus co-surgeon modifiers.

BCBSRI Co-Surgeons Payment Rules
BCBSRI utilizes Medicare payment indicators on the Medicare Physician Fee Schedule (MPFS) to determine if co-surgeon services are reasonable and necessary for a specific HCPCS/CPT code.

The MPFS is located at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

The indicators on the PFSRVU file are as follows:

- Indicator 0: Co-surgeons not permitted for this procedure
- Indicator 1: Co-surgeons could be paid, though supporting documentation is required to establish the medical necessity of two surgeons for the procedure.
- Indicator 2: Co-surgeon permitted, and no documentation required of the two specialty requirement is met.
- Indicator 9: Concept does not apply

BCBSRI will only pay as follows:

- Indicator 0: claim will deny as co-surgeon is not permitted for this procedure
- Indicator 1: claim requires review. Operative notes must be submitted by each provider at the time of claim submission.
- Indicator 2: Claims submitted by two providers with different specialties will pay. All others require claim review prior to payment. Operative notes must be submitted by each provider at the time of claim submission.
- Indicator 9: Concept does not apply.

Note: These are not medical necessity determinations and are not reviewed for medical necessity if appealed. The payment determination is a contractual payment policy.

Participating physicians may not require members to pay a co-surgeon fee even if the members accept responsibility to do so, as this is charging outside of the approved amount.

4. Bilateral Surgery

BCBSRI has adopted CMS payment policies with respect to bilateral services. In limited cases, CMS and CPT coding guidelines may differ in the correct use of modifier 50. In those cases, BCBSRI will follow the CPT coding guidelines. For example, some CPT codes have "unilateral or bilateral" in the descriptor making it clear the service is inherently bilateral. While CMS may allow use of a bilateral modifier BCBSRI will following CPT guidelines and deny the claim if filed with a bilateral modifier.

Bilateral Surgery Payment Rules

The Medicare Physician Fee Schedule Relative Value Unit (RVU) file (currently labeled PPRRVUxx.xlsx) has a column labeled "Bilat Surg." In the column are indicator numbers 0, 1, 2, 3, or 9. Even though the indicator is labeled "surgery," a designation is made for every service. The indicators have the following effects and rationales:

0: The modifiers 50, -RT, and -LT do not apply. The code represents a single side and/or both sides. Payment for one or both sides is the lower of the total charges or 100 percent of the allowance for a single side.

1: This designation indicates that the second side is treated as a multiple procedure and is accordingly reduced whether a modifier or two units of service are reported. BCBSRI does not typically unit price surgical services subject to multiple procedure reduction. Therefore, use modifiers. Payment is at 150 percent for -50 or combined -RT and –LT.

2: The service is bilateral by description. (In most cases application of modifiers or units is incorrect coding as the descriptor is explicitly bilateral.) Use of 50, -RT, -LT, or 2 units is not applicable. Payment is the lower of the charge or 100 percent of the service allowance.

3: This indicator does not occur on any surgeries. It is seen mostly in imaging of limbs and some eye codes. For procedures with status 3, we ask that you report each side as a single line using -RT/-LT. Payment is based on 100 percent for each side or the total charge if lower.

9: The concept of "bilateral" does not apply as this is used for items such as drug codes where bilateral is nonsensical.

Coding for Bilateral Services

BCBSRI claims filed with bilateral services using the -50 modifier should be filed on one line. Bilateral claims filed using the RT and LT should be filed on two separate lines.

5. Multiple Procedure Reduction Payment (MPPR)Rules:
Surgical Reductions

BCBSRI follows the CMS Relative Value Units file for multiple surgical reductions (MSR) rules and the AMA CPT book for modifier 51 exempt codes and for add-on codes. CMS will reimburse the highest surgical procedure at 100%, and each additional separate procedure that is not considered bundled or denied at 50% of the allowable amount. Multiple procedure reductions apply to services rendered by the same physician on the same date of service.

CMS Multiple Procedure Indicators (MULT PROC) are found in the most current CMS National Physician Fee Schedule Relative Value File. The values assigned to CPT codes for reimbursement are:

- **0** No payment adjustment rules for multiple procedures apply.
- **2** Standard payment adjustment rules for multiple procedures apply.
- **3** Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family.
- **4** Special rules for the technical component (TC) of diagnostic imaging procedures apply if procedure is billed with another diagnostic imagining procedure in the same family.

9 Concept of multiple surgical reductions does not apply.

AMA CPT Modifier 51 exempt and add-on codes

Codes that are modifier 51 exempt are separately reimbursed without reducing payment if services are appropriately reported together.

Add-on codes are separately reimbursed without reducing payment when appropriately billed with proper primary procedure codes.

Diagnostic Imaging

BCBSRI reduces payment on multiple radiology services filed by the same provider, same member and same date of service. BCBSRI defines the same provider as physicians/providers in the same group practice (same Group National Provider (NPI)) who furnish multiple services to the same patient on the same day. Reduction is applicable to radiology services identified on the RVU file with an indicator 88 in the Diagnostic Family Field and filed with modifier TC or global code. The service with the highest allowance is paid at 100% and all subsequent services are paid at 60%.

There is no reduction for multiple radiology services filed with modifier 26.

6. Technical Component - TC

Technical Component refers to certain procedures that are a combination of a physician component and a technical component. Using modifier TC identifies the technical component. BCBSRI follows CMS guidelines for correct usage of the TC component. The TC modifier should only be appended to health service codes that have a 1 in the PC/TC field on the National Relative Value Field file.

7. Outpatient Hospital - Bundled Services

BCBSRI follows the Centers for Medicare and Medicaid (CMS) Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule for all codes that are covered. Codes with a status indicator of "N" on Addendum B will be set up in our claims processing system as covered but not separately reimbursed (bundled) as CMS considers payment packaged into payment for other services. Updates are posted quarterly to the CMS OPPS website by CMS. BCBSRI updates codes considered packaged into APC rates on a quarterly basis based upon the CMS fee schedule.

8. Medically Unlikely Edits (MUEs) or Maximum Unit Limits

See Maximum Units policy.

9. Diagnosis Codes

Code to the Highest Degree of Specificity

Providers who must select ICD-10 diagnosis codes should use codes that provide the highest degree of accuracy and completeness, or the greatest specificity. The Centers for Medicare and Medicaid Services (CMS) require all Medicare practitioners to use ICD-10 diagnosis codes with the highest specificity as requested by the Health Insurance Portability and Accountability Act (HIPAA).

10.Multiple Modifiers and Site of Service Modifier

BCBSRI accepts the submission of multiple modifiers. Claims filed using multiple site of service modifiers must be filed on separate claim lines. Claims filed with these modifiers on the same line will not process correctly.

11. Split Care Modifier (54, 55, 56)

BCBSRI follows CMS guidelines regarding which procedure codes are valid for use with split care modifiers 54, 55, 64. Reimbursements of modified codes are based on the CMS percentage on the RVU file.

12. Modifier 24

In order to clarify the correct use of Modifier 24 when visits in the post-operative period combine post-operative care with E/M unrelated to the procedure, the following shall apply:

The primary reason for the service shall be the unrelated condition. Incidental minor findings or lower levels of medical decision making do not warrant separate E/M reporting. The number and level of E/M in the post-operative period reflects a range of anticipated complexity and number of visits.

When eligible to be reported, the basis of code selection shall not include the key components related to the procedure post-operative E/M.

In the case of planned separate surgeries (e.g., sequential cataract surgery) that are not staged procedures, E/M within the global period related to the second planned surgery is not separately reportable unless there is a significant change in the patient's condition. Confirming plans and verification of information that would be expected to be up to date as part the routine post-operative care, will not be considered a distinct service.

13. Modifier 25

Effective October 15, 2016 claims submitted with a problem-oriented E & M code (99201-99215) or a general ophthalmological code (92002-92014) and a procedure code that has a 0, 10 or 90 day post-operative period payment on the E & M service will be reduced by 50%.

Note: E&M services that are reimbursed under a per diem, or all-inclusive payment arrangement, will not be impacted by this reduction.

BCBSRI follows CMS's guidelines regarding correct use of modifier 25 for all products. As noted in National Government (NGS) Policy Education Article on Modifier 25, use of Modifier 25 indicates a "significant, separately identifiable E&M service by the same physician on the same day of the procedure or other therapeutic service." Both services must be significant, separate and distinct. In general, Medicare considers E&M services provided on the day of a procedure to be part of the work of the procedure, and as such, does not make separate payment. The exception to that rule is when the E&M documentation supports that there has been a significant amount of additional work above and beyond what the physician would normally provide, and when the visit can stand alone as a medically necessary billable service.

When billing an E&M service along with a procedure, the documentation in the member's medical record must clearly demonstrate that:

- the purpose of the evaluation and management service was to evaluate a specific complaint;
- the complaint or problem addressed can stand alone as a billable service;
- you performed extra work that went above and beyond the typical work associated with the procedure code;
- the key components of the appropriately selected E&M service were actually performed and address the presenting complaint;
- the purpose of the visit was other than evaluating and/or obtaining information needed to perform the procedure/service; and
- both the medically necessary E&M service and the procedure are appropriately and sufficiently documented by the physician in the patient's medical record to support the claim for these services.

Following are examples that illustrate the **appropriate** use of modifier 25:

- A patient is scheduled by the podiatrist to take care of a fibrous hamartoma. During the visit, the patient indicates that he has had numbness and oozing from a lesion on his heel. The podiatrist evaluates the lesion, determines that it is a diabetic ulcer and treats it appropriately.
    - In this case the heel lesion is considered a separate and significant service.
- A patient sees a dermatologist for a lesion on his leg. During the exam, the patient mentions a rash on his arm. The symptoms have been worsening so that the patient has been unable to sleep at night due to the itching. The lesion on the leg is removed and the provider writes a prescription for the rash.

- In this case the rash is considered to be a separate and significant service.

- A patient comes to the office with complaints of right knee pain. The physician takes a history and does an exam. An X-ray of the knee is obtained, and the physician writes an order for physical therapy. He determines that the patient would benefit from a cortisone injection to the affected knee.
    - In this case, a separate and significant E&M service was prompted by the knee pain for which the cortisone injection was given.

Following are examples that illustrate the **inappropriate** use of modifier 25:

- An established patient is seen in the office for debridement of mycotic nails. In the course of examining the feet prior to the procedure, Tinea Pedis is noted. Use of previously prescribed topical cream to treat the Tinea is recommended.
    - In this case the Tinea was noted incidentally in the course of the evaluation of the mycotic nails and did not constitute a significant and separately identifiable E&M service above and beyond the usual pre and post care associated with nail debridement.
- A patient is seen in the office for simple repair of a laceration of the right finger. It is determined that it has been longer than ten years since his last Td vaccine. After the repair, the wound is dressed, wound care instructions are given, and a Td booster is administered.
    - The work done is considered part of the typical care associated with this type of injury. An E&M component is included in the pre and post work for the laceration.

In all cases where modifier 25 is appropriately employed, the provider must ensure that documentation is present in the patient's medical record to fully substantiate both the visit and the procedure.

14. Modifier 59, XE, XS, XP, XU

BCBSRI follows CMS guidelines regarding use of the specific subsets of modifier 59. Effective January 1, 2015 CMS established four new Healthcare Common Procedure Coding System (HCPCS) modifiers to define subsets of modifier 59, a modifier used to define a "Distinct Procedural Service."

CMS established the following four new HCPCS modifiers (referred to collectively as -X{EPSU} modifiers) to define specific subsets of the -59 modifier:

- XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter,
- XS Separate Structure, A Service That Is Distinct Because It Was Performed on A Separate Organ/Structure,
- XP Separate Practitioner, A Service That Is Distinct Because It Was Performed by A Different Practitioner, and

- XU Unusual Non-Overlapping Service, the Use of a Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

CPT instructions state that modifier 59 should not be used when a more descriptive modifier is available so the use of modifier 59 should be very limited. CMS guidelines cite that the –X {EPSU} modifiers are more selective versions of modifier 59 so it would be incorrect to include both modifiers on the same line.

15. Split (or shared) E/M visits

Effective January 1, 2022, CMS has refined their longstanding policies for split (or shared) E/M visits to better reflect the current practice of medicine, the evolving role of non-physician practitioners (NPPs) as members of the medical team, and to clarify conditions of payment that must be met to bill Medicare for these services. In the CY 2022 PFS final rule, CMS established the following:

Definition of split (or shared) E/M visits provided in the facility setting by a physician and/or an NPP in the same group. The visit is billed by the physician or practitioner who provides the substantive portion of the visit.

Please Note: These modifiers/rule does not apply to E/M services provided in an office setting (Place of Service 11).

For 2022, the substantive portion can be history, physical exam, medical decision-making, or more than half of the total time (except for critical care, which can only be more than half of the total time). By 2023 it is anticipated the substantive portion of the visit will be defined as more than half of the total time spent.

Split (or shared) visits can be reported for new as well as established patients, and initial and subsequent visits, as well as prolonged services.

CMS has indicated a modifier is required on the claim to identify these services to inform policy and help ensure program integrity. Documentation in the medical record must identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record. This is also, BCBSRI's requirement.

The modifiers related to split (or shared) E/M visits are:

- FQ The service was furnished using audio-only communication technology
- FR The supervising practitioner was present through two-way, audio/video communication technology
- FS Split (or shared) evaluation and management visit
- FT Unrelated evaluation and management (e/m) visit during a postoperative period, or on the same day as a procedure or another e/m visit. (report when an e/m visit is furnished within the global period but is unrelated, or when one or more additional e/m visits furnished on the same day are unrelated

16. 340B-Acquired Drugs use Modifiers JG and TB

For CY 2023, CMS maintains the requirement for 340B providers to report the JG and TB modifiers for informational purposes. Under the OPPS, select entities including rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals should continue to bill the modifier TB on claim lines for drugs acquired through the 340B Program. All other 340B providers should continue to report the modifier JG.

Additional information on BCBSRI recognized modifiers:

Billing Information

Refer to the most updated industry standard coding guidelines for a complete list of modifiers and their usage. In the instances when a modifier is submitted incorrectly with the procedure code, BCBSRI will deny the claim line for incorrect use of modifier.

The list below represents the most common modifiers used and identifies how they are used by BCBSRI for claims processing. This is not an all-inclusive list of modifiers.
Note: The absence or presence of a modifier may result in a claim being denied.

CPT Modifier	Modifier Description	System Indications	Reimbursement Impact
22	Unusual procedural services	Claims review for additional payment/not state supplied	Claim review required. Exception for BCBSRI: Modifier 22 is also used to differentiate

			when vaccine is not supplied by the state.
23	Unusual anesthesia	Informational	Informational only.
24	Unrelated evaluation and management service by the same physician during the postoperative period	Payment during a global period	Payment allowed based on percentage of contracted rate.
25	Significant, separately identifiable evaluation and management service by the same provider on the same day of the procedure or other service	Problem oriented E & M 99201-99215) or general ophthalmological code (92002-92014) billed with a procedure code having a 0, 10 or 90 day post-operative period.	Payment for 99201-99215 or 92002-92014 will be reduced by 50%, all other E & M's will pay based on contracted allowance.
26	Professional component	Percentage of payment	Payment allowed based on percentage of contracted rate.
32	Mandated services	Payment	Payment allowed based on percentage of contracted rate.
47	Anesthesia by surgeon	Informational	Informational
50	Bilateral procedure	Multiple procedure payment	Payment made at 150% of base code fee
51	Multiple procedures	Multiple procedure payment	Primary procedure reimbursed at 100% of allowance and subsequent procedures reimbursed at 50% of allowance (other than add-on or 51 exempt codes).
52	Reduced services	Payment	Payment made at 80%
53	Discontinued services	Payment	Payment is made at 50% of the allowable (effective 10/1/2014)
54	Surgical care only	Percentage of payment	Payment made at % of base code fee as outlined in CMS Physician RVU file.
55	Postoperative care only	Percentage payment	Payment made at % of base code fee as outlined in CMS Physician RVU file.
56	Preoperative care only	Percentage payment	Payment made at % of base code fee as outlined in CMS Physician RVU file.
57	Decision for surgery	Global payment	Payment allowed based on percentage of contracted rate.

58	Staged or related procedure or service by the same physician during the postoperative period	Global percentage payment	Payment allowed based on percentage of contracted rate.
59, XE, XS, XP, XU	Distinct procedural service	Payment	Payment allowed. Use of modifier 59 should be limited as providers should use one of the more specific HCPCS modifiers. Refer to the Modifier 59 policy in the related policy section
62	Two surgeons/ Co-surgeons	Payment	Payment made at 62.5% of base code fee allowance
63	Procedure performed on infants	Informational	Informational only.
66	Surgical team	Informational	Informational
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia	Payment	Payment will be made at 50% of allowance
74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia	Payment	Payment will be made at 100% of allowance
76	Repeat procedure by the same physician	Global payment	Payment allowed based on percentage of contracted rate. **Modifier 76 not recognized on surgical codes.**
77	Repeat procedure by another physician	Global payment	Payment allowed based on percentage of contracted rate. **Modifier 77 not recognized on surgical codes.**
78	Unplanned return to the operating room by the same physician following the initial procedure for a related procedure during the postoperative period	Global percentage of payment	Payment allowed based on percentage of contracted rate.
79	Unrelated service or procedure by the same physician during the postoperative period	Global payment	Payment allowed based on percentage of contracted rate.

80	Assistant surgeon	Claim review percentage of payment	BCBSRI will only pay for an assistant surgeon for those procedures with an indicator 2 (assistant surgeon may be paid)
81	Minimum assistant surgeon	Claim review percentage of payment	BCBSRI will only pay for an assistant surgeon for those procedures with an indicator 2 (assistant surgeon may be paid)
82	Assistant surgeon (when qualified resident surgeon not available)	Claim review percentage of payment	Claims review required. Percentage based on contracted rate.
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System	Informational	Informational only
P1 –P6	Anesthesia Modifiers-Physical Status Modifiers	Informational	Informational only
HCPCS Modifiers *multiple site of service modifiers must be filed on separate claim lines			
Ambulance Modifiers			See Ground Ambulance policy.
AA	Anesthesia service performed personally by anesthesiologists	Payment	Payment allowed based on percentage of contracted rate.
AB	Audiology service furnished personally by an audiologist without a physician/NPP order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids; service may be performed once every 12 months, per beneficiary	Payment	Payment allowed based on contracted rate.
AH	Clinical psychologist	Payment	Payment allowed based on percentage of contracted rate.
AJ	Clinical social worker	Payment	Payment allowed based on percentage of contracted rate.
AS	Assistant surgeon for mid-levels	Claim review percentage payment	Claim review required. Percentage based on contracted rate. NOTE: BCBSRI does not review AS modifier for medical necessity. When medical necessity review is required for payment by **Medicare**

			Advantage Plans, BCBSRI denies additional payment under the provider contract- Provider liability.
E1*	Upper left eyelid	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
E2*	Lower left eyelid	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
E3*	Upper right eyelid	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
E4*	Lower right eyelid	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
EP	Early intervention	Payment	Payment allowed based on state reimbursement.
F1*	Left hand, second digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
F2*	Left hand, third digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
F3*	Left hand, fourth digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
F4*	Left hand, fifth digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
F5*	Right hand, thumb	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
F6*	Right hand, second digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
F7*	Right hand, third digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
F8*	Right hand, fourth digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
F9*	Right hand, fifth digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
FA*	Left hand, thumb	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
FQ	The service was furnished using audio-only communication technology	Informational	Informational only

FR	The supervising practitioner was present through two-way, audio/video communication technology	Informational	Informational only
FS	Split (or shared) evaluation and management visit	Informational	Informational only
FT	Unrelated evaluation and management (e/m) visit during a postoperative period, or on the same day as a procedure or another e/m visit. (report when an e/m visit is furnished within the global period but is unrelated, or when one or more additional e/m visits furnished on the same day are unrelated	Informational	Informational only
GA	Waiver of liability statement issued as required by payer policy, individual case	Payment	Indicates claims will deny as member liability for health service.
GC	This service has been performed in part by a resident under the direction of a teaching physician	Payment	Payment allowed based on percentage of contracted rate.
GO	Services delivered under an outpatient occupational therapy plan of care	Payment	Claim will deny as provider liability if modifier is missing
GP	Services delivered under an outpatient physical therapy plan of care	Payment	Claim will deny as provider liability if modifier is missing
GU	Waiver of liability statement issued as required by payer policy, routine notice	Payment	Claims will deny as member liability for health service.
GX	Notice of liability issues, voluntary under payer policy	Payment	Claims will deny as member liability for health service.
GY	Item or service is not covered	Payment	Claims will be not covered.
JG	indicates drug or biological was acquired with 340B drug pricing program discount	Informational	Informational Only
JW	Drug amount discarded/not administered to any patient (single dose package)	Payment	Payment allows for the amount of discarded drug or biological.
JZ	No discarded Drug amount /not administered to any patient (single dose package)	Informational	Informational Only (effective date: 7/1/2023)
KS	Requirements specified in the medical policy have been met	Payment	Payment allows when medical criteria are met
KX	Requirements specified in the medical policy have been met	Payment	Payment allows when medical criteria are met
LT*	Left	Multiple surgery payment	Payment allowed based on percentage of contracted rate.

LU	Fractionated payment of car-t therapy	Payment	Payment allowed based on percentage of contracted rate.
N1	Group 1 oxygen coverage criteria met for DME	Payment	Payment allowed based on percentage of contracted rate.
N2	Group 2 oxygen coverage criteria met for DME	Payment	Payment allowed based on percentage of contracted rate.
N3	Group 3 oxygen coverage criteria met for DME	Payment	Payment allowed based on percentage of contracted rate.
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.	Payment	Payment is at 50 percent of allowable
QS	Monitored anesthesia care services - MAC	Informational	Informational only.
QW	CLIA waived test	Payment	Payment allowed based on percentage of contracted rate.
QX	CRNA medical direction by physician	Payment	Payment is at 50 percent of allowable
QY	Medical direction of one CRNA by an anesthesiologist	Payment	Payment is at 50 percent of allowable
QZ	CRNA service: without medical direction of a physician	Payment	Payment is at 100 percent of allowable
RA	Replacement of a DME, Orthotic or Prosthetic Item	Informational	Payment allowed based on percentage of contracted rate.
RB	Replacement of a Part of a DME, Orthotic or Prosthetic Item Furnished as Part of a Repair	Informational	Payment allowed based on percentage of contracted rate.
RR	Rental	Payment	Payment allowed based on percentage of contracted rate.
RT*	Right	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
SA	Nurse Practitioner rendering service in collaboration with physician	Nurse Practitioner rendering service in collaboration with a physician	Payment	Payment is reduced 15% of contracted rate
T1*	Left foot, second digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
T2*	Left foot, third digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
T3*	Left foot, fourth digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.

T4*	Left foot, fifth digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
T5*	Right foot, great toe	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
T6*	Right foot, second digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
T7*	Right foot, third digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
T8*	Right foot, fourth digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
T9*	Right foot, fifth digit	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
TA*	Left foot, great toe	Multiple surgery payment	Payment allowed based on percentage of contracted rate.
TB	Indicates drug or biological was acquired with 340B drug pricing program discount	Informational	Informational only
TC	Technical Component	Percentage of payment	Payment allowed based on percentage of contracted rate.
TU	Special payment rate	Prolonged services payment	Claims require review.

Note: For any claim that review is required, the clinical documentation must be sent to the following address:

Individual Consideration Unit of Basic Claims
Administration Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, RI 02903 -2699

COVERAGE
Not applicable as this policy is a reference document

CODING
See Policy section

RELATED POLICIES
Maximum Units
Modifier 59, XE, XP, XS, XU Guidelines
Modifier 22

PUBLISHED
Provider Update, August 2023
Provider Update, June 2023
Provider Update, April 2023
Provider Update, May 2022

Provider Update, May 2020
Provider Update, April 2020
Provider Update, June 2019
Provider Update. May 2018
Provider Update, February 2018

REFERENCES

1. CMS National Correct Coding Initiatives Edits
https://www.cms.gov/NationalCorrectCodInitEd/CMS Physician Fee Schedule
https://www.cms.gov/PhysicianFeeSched/
2. How to use the National Correct Coding Initiative (NCCI) Tools
https://www.cms.gov/MLNProducts/downloads/How-To-Use-NCCI-Tools.pdf
3. https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
4. National Government Services Education Policy Modifier 25
https://www.ngsmedicare.com/ngs/portal/ngsmedicare/newngs/home-lob/pages/policy-education/modifiers/modifier
5. CMS MUE's https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html
6. Calendar Year (CY) 2022 Medicare Physician Fee Schedule Final Rule
7. MLN Matters MM13031 - Hospital Outpatient Prospective Payment System: January 2023 Update (cms.gov)
8. https://med.noridianmedicare.com/web/jeb/topics/claim-submission/modifier-and-hcpcs-changes/2023