PAYMENT POLICY ID NUMBER: 10-011

Original Effective Date: 05/14/10

Revised: 10/19/2023

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 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 Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (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:

While up to four modifiers are accepted per claim line, modifiers affecting reimbursement should be submitted in the first and second position on paper and electronic claims.

BILLING/CODING INFORMATION:

Modifier	Description	Billing Standards/Reimbursement	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 Evaluation and Management (E/M) service. Clinical records required for review.	Increased Procedural Services; Obstetric Services
24	**Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period:** The physician or other qualified health care professional may need to indicate that an E/M service was performed during a postoperative period for a reason(s) unrelated to the original procedure.	Clinical records may be required to establish service was not related to surgical service.	Global Surgery Package
25	**Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional 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 and postoperative care associated with the procedure that was performed.	This modifier should be used with E/M codes only and not appended to surgical procedure codes. Documentation should clearly demonstrate a separate E/M service was performed.	Global Surgery Package; Multiple Visit Reduction; Obstetric Services
26	**Professional Component:** Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.	When a patient receives services as a hospital inpatient or outpatient, the physician or others health care professional should report the professional component of services that have both a professional and technical component. Physicians and others health care professionals will be reimbursed only for the professional component and should not report modifier TC.	Professional Technical Component; Multiple Imaging Reduction

Modifier	Description	Billing Standards/Reimbursement	Refer to Payment Policy
33	**Preventive Services:** When the primary purpose of the service is the delivery of an evidence based service in accordance with the US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the preventive service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.	May be used to identify preventive services.	
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 performed by the surgeon is not payable and should not be reported.	Anesthesia Services
50	**Bilateral Procedure:** Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate five digit code.	For professional claims, bilateral surgical procedures should be reported on two separate claim lines with "1" unit for each line along with modifiers LT/RT. Additionally, it is acceptable to report a bilateral procedure on a single line with modifier 50 and "2" units. This code should not be appended on designated "add-on" codes	Bilateral Procedures, Multiple Surgical 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 may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).	This modifier should not be appended to designated add-on codes. Modifier 51 is not required to identify procedures to be reduced under multiple surgical procedure reduction.	Multiple Surgical Procedure Reduction (Including Multiple Endoscopic Procedure Reduction)

Modifier	Description	Billing Standards/Reimbursement	Refer to Payment Policy
52	**Reduced Services:** Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. 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.	Allowed amount is reduced by 50%.	Reduced Services
53	**Discontinued Procedure:** Under certain circumstances, the physician or other qualified health care professional 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 to the code reported by the individual for the discontinued procedure.	Allowed amount is reduced by 50%.	Discontinued Procedure
54	**Surgical Care Only:** When one physician or other qualified health care professional 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.	Allowed amount is 70% of the normal fee schedule amount.	Split Surgical Package
55	**Postoperative Management Only:** When one physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.	Allowed amount is 30% of the normal fee schedule amount.	Split Surgical Package
56	**Preoperative Management Only:** When one physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.	Modifier 56 should not be used. Report services for the preoperative component by a different physician with an appropriate E/M code.	Split Surgical Package

Modifier	Description	Billing Standards/Reimbursement	Refer to Payment Policy
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 when the decision for surgery is for a major surgical procedure.	Global Surgery Package
58	**Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period:** It may be necessary to indicate that the performance of a procedure or service during the postoperative period was (a) planned or anticipated; (b) more extensive than the original procedure; or (c)for therapy following a surgical procedure.	For unplanned returns to operating room, please reference modifier 78.	Global Surgery Package
59	**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day.	Modifier should not be reported with E/M codes.	National Correct Coding Initiative; Unbundled, Incidental, and Mutually Exclusive Services
62	**Two Surgeons:** When two surgeons work together as primary surgeons performing distinct part(s) 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 code(s) for that procedure as long as both surgeons continue to work together as primary surgeons.	Each surgeon is reimbursed at 62.5% of the usual fee schedule amount.	Co-Surgeons (Two Surgeons)
76	**Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional:** It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service.	The modifier should not be reported with E/M codes. For repeat laboratory services performed on the same day, use modifier 91. For multiple specimens or multiple sites use modifier 59.	Maximum Units of Service

Modifier	Description	Billing Standards/Reimbursement	Refer to Payment Policy
77	**Repeat Procedure by Another Physician or Other Qualified Health Care Professional:** It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service.	The modifier should not be reported with E/M codes	
78	**Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional 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.	Allowed amount is 70% of the normal fee schedule amount.	Global Surgery Package
79	**Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period:** The individual 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 number(s).	Reported when a physician acts as the assistant surgeon. Allowed amount is 16% of the ordinary fee schedule.	Surgical Assistant
81	**Minimum Assistant Surgeon:** Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.	Reported when a physician acts as the assistant surgeon. Allowed amount is 16% of the ordinary fee schedule.	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.	Reported when a physician acts as the assistant surgeon. Allowed amount is 16% of the ordinary fee schedule.	Surgical Assistant
91	**Repeat Clinical Diagnostic Laboratory Test**		Maximum Units of Service

Modifier	Description	Billing Standards/Reimbursement	Refer to Payment Policy
95	**Synchronous Telemedicine service rendered via a real-time interactive audio and video telecommunications system**		Virtual Visits
96	**Habilitative Services**	Habilitative services should be reported with modifier 96.	Reporting Habilitative and Rehabilitative Services
97	**Rehabilitative Services**	Rehabilitative services should be reported with modifier 97.	Reporting Habilitative and Rehabilitative Services
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 BCBSFL for reimbursement.	Anesthesia Services
AS	**Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery**	Reported when physician assistant, registered nurse first assistant or other clinical nurse specialist acts as the assistant at surgery. Allowed amount is generally 13.6% of the ordinary fee schedule amount.	Surgical Assistant
E1-E4	**Anatomic modifiers associated with eyelids**		National Correct Coding Initiative; Unbundled, Incidental, and Mutually Exclusive Services
F1-F9, FA	**Anatomic modifiers associated with fingers**		National Correct Coding Initiative; Unbundled, Incidental, and Mutually Exclusive Services
FT	**Unrelated E/M visit during a postoperative period**	For use with critical care performed by a surgeon during a global period when the critical care is unrelated to the surgical procedure. Clinical records may be required to establish service was not related to surgical service.	Global Surgery Package

Modifier	Description	Billing Standards/Reimbursement	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
GT	**Via interactive audio and video telecommunication systems**		Virtual Visits
LC, LD, LM, RC, RI	**Anatomic modifiers associated with coronary arteries**		National Correct Coding Initiative
LT	**Left Side:** Used to identify procedures performed on the left side of the body.	Procedures that can be performed on the left or right side should be reported with the appropriate modifier (LT or RT).	Bilateral Procedures; National Correct Coding Initiative; Unbundled, Incidental, and Mutually Exclusive Services
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 of two, three, or four concurrent anesthesia procedures involving qualified individuals**	Time based anesthesia services require an anesthesia modifier. Reported by a physician and is reimbursed at 50% of the fee schedule rate.	Anesthesia Services
QS	**Monitored anesthesia care services**	Only one QS service per day will be allowed.	Anesthesia Services

Modifier	Description	Billing Standards/Reimbursement	Refer to Payment Policy
QX	**CRNA service: with medical direction by a physician**	Time based anesthesia services require an anesthesia modifier. Reported by a CRNA and is reimbursed at 50% of the fee schedule rate.	Anesthesia Services
QY	**Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist**	Time based anesthesia services require an anesthesia modifier. Reported by a physician and is reimbursed at 50% of the fee schedule rate.	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.	Procedures that can be performed on the left or right side should be reported with the appropriate modifier (LT or RT).	Bilateral Procedures: National Correct Coding Initiative; Unbundled, Incidental, and Mutually Exclusive Services
SH	**Second Concurrently Administered Infusion Therapy**	Modifier SH may be used to denote multiple therapies.	Multiple Procedure Reduction - Home Infusion Therapy Per Diem
SJ	**Third or More Concurrently Administered Infusion Therapy**	Modifier SJ may be used to denote multiple therapies	Multiple Procedure Reduction - Home Infusion Therapy Per Diem
SL	**State supplied vaccine**	Modifier SL must be used to identify vaccine(s) obtained at no cost to the provider. Florida Blue will not reimburse vaccine(s) obtained at no cost to the provider. Florida Blue may reimburse for the administration of the vaccine(s) in accordance with the patient's benefit coverage.	
T1-T9, TA	**Anatomic modifiers associated with toes**		National Correct Coding Initiative; Unbundled, Incidental, and Mutually Exclusive Services

Modifier	Description	Billing Standards/Reimbursement	Refer to Payment Policy
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.	When a patient receives services as a hospital inpatient or outpatient, the facility should report the technical component of services that have both a professional and technical component. Physicians and other health care professionals will be reimbursed only for the professional component and should not report modifier TC.	Professional/ Technical Component; Multiple Imaging Reduction
XE	**Separate encounter –** a service that is distinct because it occurred during a separate encounter	Modifier should not be reported with E/M codes.	National Correct Coding Initiative; Unbundled, Incidental, and Mutually Exclusive Services
XP	**Separate practitioner –** a service that is distinct because it was performed by a different practitioner	Modifier should not be reported with E/M codes.	National Correct Coding Initiative; Unbundled, Incidental, and Mutually Exclusive Services
XS	**Separate structure –** a service that is distinct because it was performed on a separate organ/structure	Modifier should not be reported with E/M codes.	National Correct Coding Initiative; Unbundled, Incidental, and Mutually Exclusive Services
XU	**Unusual non-overlapping service –** the use of a service that is distinct because it does not overlap usual components of the main service	Modifier should not be reported with E/M codes.	National Correct Coding Initiative; Unbundled, Incidental, and Mutually Exclusive Services

REFERENCES:

1. American Medical Association, Current Procedural Terminology (CPT®), Professional Edition
2. Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System (HCPCS) Level II, Professional Edition

GUIDELINE UPDATE INFORMATION:

05/14/2010	New Payment Policy
05/31/2012	Revised – Changed name from BCBSF to Florida Blue

09/08/2016	Annual Review: Content updated, modifiers added.
09/14/2017	Annual Review
09/20/2018	Annual Review: added modifiers -33, -77, -96, & -97 and made some minor verbiage changes to some of the modifier descriptions
09/12/2019	Annual Review – updated Billing Standards/Reimbursement & Refer to Payment Policy for several modifiers
09/10/2020	Annual Review – added modifiers 95 and GT
09/16/2021	Annual Review – Virtual Visit payment policy referral added to Modifier 95 and GT. Updated Billing Standards/Reimbursement section for Modifier 58. References updated.
09/15/2022	Annual Review – Modifier FT added with reference to Global Surgery Package payment policy
09/14/2023	Annual Review – Modifiers SH and SJ added with reference to Multiple Procedure Reduction - Home Infusion Therapy Per Diem payment policy. In addition, anatomical modifiers LC, LD, LM, RC, RI added with reference to NCCI payment policy.
10/19/2023	Revision – Modifiers SL added.