ConnectiCare

Reimbursement Policy:

Modifier Reference Policy (Commercial)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RPC20210015	9/01/2021	**RPC (Reimbursement Policy Committee)**

Reimbursement Guideline Disclaimer: We have policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. We will inform you of new policies or changes in policies through postings to the Reimbursement Policies webpage on connecticare.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in our policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, we strive to minimize these variations.

We follow coding edits that are based on industry sources, including, but not limited to, CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. We use industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Overview:

The tables below represent modifiers that are addressed in ConnectiCare's reimbursement policies. It is not an all-inclusive list.

For complete list of modifiers, refer to the Current Procedure Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) coding guidelines manuals.

Please review the Reimbursement Policy section of our website:

- *ConnectiCare: https://www.connecticare.com/providers/our-policies/reimbursement-policies*

for additional policies containing appropriate use guidelines for some of the modifiers referenced in this policy.

Modifier Reference Tables:

Modifier	Description	CPT Codes Where Modifier May Apply:	Reimbursement Impact/Policy Reference:
22	Unusual Procedural Service	10021-99199 *This modifier should not be appended to an E/M service.*	Additional 20% of the allowable fee (120% of fee)
24	Unrelated E/M Service by the Same Physician During a Postoperative Period"	This modifier is only used with E/M services in the CPT codebook. It is not used in any other section of the CPT codebook	Evaluation & Management (E&M), NCCI Edits

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Modifier	Description	CPT Codes Where Modifier May Apply:	Reimbursement Impact/Policy Reference:
25	Significant, Separately Identifiable E/M Service by the Same Physician on the Same Day of the Procedure or Other Service	This modifier is used with E/M services in the CPT codebook.	Evaluation & Management (E&M), NCCI Edits
26	Professional Component	70010-99199	Reduced % based on contracted fee schedule
50	Bilateral Procedure	10021-69990	Additional 50% of the allowable fee (150% of the fee)
51	Multiple Procedures		Multiple Procedure Reduction
52	Reduced Services	All	Reduced the allowable fee by 50% (pays 50% of fee)
53	Discontinued Procedure	All	Reduced the allowable fee by 50% (pays 50% of fee)
54	Surgical Care Only	10021-69990	Reduced the allowable fee by 20% (pays 80% of fee)
55	Postoperative Management Only	10021-69990	Reduced the allowable fee by 80% (pays 20% of the fee)
56	Preoperative Management Only	10021-69990	Reduced the allowable fee by 100% (pays 0% of the fee)
57	Decision for Surgery	This modifier is only used with an E/M service	Evaluation & Management (E&M), NCCI Edits
58	Staged or Related Procedure by the same physician or other qualified health care professional during the postoperative period		NCCI Edits, Bundled Codes
59	Distinct Procedural Services	All	Allows separate reimbursement for procedures that would otherwise deny per code editing (e.g., separate excision site). If the code being billed is subject to multiple surgery procedure reimbursement reduction, the applicable reduction will also apply.
62	Two Surgeons	10021-69990	Reduced the allowable fee by 37% (pays 63% of fee)
63	Procedure Performed on Infants less than 4 kg	20100-69990; 92920, 92928, 92953, 92960, 92986, 92987, 92990, 92997, 92998, 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93452, 93505, 93530, 93531, 93532, 93533, 93561, 93562, 93563, 93564, 93568, 93580, 93582, 93590, 93591, 93592, 93615, 93616	Additional 20% of the allowable fee (120% of fee)

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Modifier	Description	CPT Codes Where Modifier May Apply:	Reimbursement Impact/Policy Reference:
66	Surgical Team		Co-Surgeon/Team Surgeon, Multiple Procedure Reduction
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia	All	Reduced the allowable fee by 50% (pays 50% of fee)
74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia	All	
76	Repeat Procedure by Same Physician or Other Qualified Health Care Professional	10021-99199 This modifier should not be appended to an E/M service. For repeat laboratory tests performed on the same day, use modifier 91. For multiple specimen/sites use modifier 59	Reduced the allowable fee by 20% (pays 80% of fee)
78	Return to the Operating Room for a Related Procedure during the Postoperative Period	10021-69990	Reduced the allowable fee by 20% (pays 80% of fee)
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period		
80	Assistant Surgeon	10021-69990	Reduced the allowable fee by 84% (pays 16% of fee); mid-level practitioners may not bill with this modifier; service may be denied if the procedure is not one that would normally warrant the services of an assistant surgeon
81	Minimum Assistant Surgeon	10021-69990	Reduced the allowable fee by 84% (pays 16% of fee); mid-level practitioners may bill with this modifier; service may be denied if the procedure is not one that would normally warrant the services of an assistant surgeon
82	Assistant Surgeon (when qualified resident surgeon not available)"	10021-69990	Reduced the allowable fee by 84% (pays 16% of the fee); mid- level practitioners may not bill with this modifier, use AS or 81 instead; service may be denied if the procedure is not one that would normally warrant the services of an assistant surgeon

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Modifier	Description	CPT Codes Where Modifier May Apply:	Reimbursement Impact/Policy Reference:
91	Repeat Clinical Diagnostic Laboratory Test		Laboratory/Venipuncture Codes
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System		*New modifier effective 1/01/2022*
PA	Surgical or other invasive procedure on wrong body part		Reduced the allowable fee by 100% (pays 0%)
PB	Surgical or other invasive procedure on wrong patient		Reduced the allowable fee by 100% (pays 0%)
PC	Wrong surgery or other invasive procedure on patient		Reduced the allowable fee by 100% (pays 0%)
AS	Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Service for Assistant at Surgery	10021-69990	Reduced the allowable fee of 16% by 85%; mid-level practitioners may bill with this modifier; service may be denied if the procedure is not one that would normally warrant the services of an assistant surgeon.
AX	Item furnished in conjunction with dialysis services	A4244-A4247, A4450, A4452, A4656-A4657, A4660, A4663, A4670, A4712, A4927-A4928, A4930-A4931, A6250, A6260, E0210, E1632, E1637-E1639, J0879, J1644	Drugs used for bone and mineral metabolism for the treatment of End Stage Renal Disease are eligible for Transitional Drug Add-On Payment Adjustment when reported with AX modifier. **Add-on payment is applicable to Medicare facilities only.*
FQ	The service was furnished using audio-only communication technology		*New modifier effective 1/01/2022*
FR	The supervising practitioner was present through two-way, audio/video communication technology		*New modifier effective 1/01/2022*
FS	Split (or shared) evaluation and management visit		*New modifier effective 1/01/2022*

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Modifier	Description	CPT Codes Where Modifier May Apply:	Reimbursement Impact/Policy Reference:
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)		*New modifier effective 1/01/2022*
FX	X-ray taken using film	Any radiology code	*Reduce the allowable fee by 10% effective 1/01/2023 (pays 90%)*
FY	X-ray taken using computed radiography technology/cassette-based imaging	Any radiology code	*Reduce the allowable fee by 10% effective 1/01/2023 (pays 90%)*
JW	Drug amount discarded and not administered to any patient	Medicare Part B Drugs from single-dose containers/single-use package	*See our Discarded Drugs/Biologicals – Modifiers JW & JZ Reimbursement Policy for complete guidance*
JZ	Zero drug wasted or discarded and not administered to any patient	Medicare Part B Drugs from single-dose containers/single-use package	*See our Discarded Drugs/Biologicals – Modifiers JW & JZ Reimbursement Policy for complete guidance*
QE	Prescribed amount of stationary oxygen while at rest is less than 1 liter per minute (LPM)		Reduced the allowable fee by 50% (pays 50% of fee)
QW	CLIA Waived Test		*Non-CLIA waived tests submitted with QW modifier will be denied.*
SG	Ambulatory surgical center (ASC) facility service		
SU	Procedure performed in physician's office (to denote use of facility & equipment)		Reduced the allowable fee by 100% (pays 0%) *See our Modifier SU-Procedure Performed in Physician's Office (Facility & Equipment) Reimbursement Policy for complete guidance*
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter		
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner.		
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure		

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Modifier	Description	CPT Codes Where Modifier May Apply:	Reimbursement Impact/Policy Reference:
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service		
CT	Computed tomography [CT] services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association [NEMA] XR-29-2013 standard	70450-70498, 71250-71275,72125-72133,72191-72194,73200-73206, 73700-73706,74150-74178,75571-75574 (and any succeeding codes)	Reduces the allowable by 15% (pays 85%)
TC	Technical Component	70010-99199	Reduced % based on contracted fee schedule

Anesthesia Physical Status Modifiers

The Anesthesia Physical Status Modifiers listed below will affect provider reimbursement.
Refer to our Anesthesiology Reimbursement Policy for billing instructions.

Modifier	Description	CPT Codes Where Modifier May Apply	Unit Value
P1	A normal healthy patient	All anesthesia services are reported with the use of codes: **00100-01999** with the appropriate physical status modifier appended *Note: CPT codes 01953 and 01996 do not require anesthesia modifiers.*	0
P2	A patient with mild systemic disease		0
P3	A patient with severe systemic disease		1 (15 min)
P4	A patient with severe systemic disease that is a constant threat to life		2 (30 min)
P5	A moribund patient who is not expected to survive without the operation		3 (45 min)
P6	A declared brain-dead patient whose organs are being removed for donor purposes		0

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Modifier	Description	Reimbursement Impact/Policy Reference:
AA	Anesthesia services performed personally by anesthesiologist	100%
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	50%
QK	Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals	50%
QX	CRNA service: with medical direction by a physician	50%
QY	Medical direction of one qualified non-physician anesthetist by an anesthesiologist	50%
QZ	CRNA service; without medical direction of a physician	100%

Informational Only Modifiers:

NOTE: When Reporting modifiers 23, 47, GC, G8, G9 or QS; no additional reimbursement is allowed above the usual fee for that service.

Modifier	Description
23	Unusual Anesthesia
47	Anesthesia by Surgeon
GC	This service has been performed in part by a resident under the direction of a teaching physician.
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure.
G9	Monitored anesthesia care (MAC) for patient who has a history of severe cardiopulmonary condition.
QS	Monitored anesthesiology care services (can be billed by a qualified non-physician anesthetist or a physician).

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Ambulance Modifiers

The Ambulance Modifiers listed below do not affect provider reimbursement.

Note: The first letter indicates the transport's place of origin, the destination is indicated by the second modifier (e.g. RH would indicate ambulance transport from a resident to a hospital)

Modifier	Description
D	Diagnostic or Therapeutic site other than "P" or "H" when those codes are used as origin codes
E	Residential, domiciliary, custodial facility (other than a skilled nursing facility)
G	Hospital based dialysis facility (hospital or hospital related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between types of ambulance
J	Non-hospital based dialysis facility
N	Skilled nursing facility
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	(Destination code only) intermediate stop at physician's office on the way to the hospital
GM	Multiple patients on one ambulance trip
TQ	Basic life support transport by a volunteer ambulance provider
QL	Patient pronounced dead after ambulance called
QM	Ambulance service provided under arrangement by a provider of services
QN	Ambulance service furnished directly by a provider of services

Site-Specific Modifiers

The Site-Specific Modifiers listed below do not affect provider reimbursement.

Modifier	Description	CPT Codes Where Modifier May Apply
E1-E4	Anatomic modifiers which are associated with the eyelid	10021-68899
FA, F1-F9	Anatomic modifiers which are associated with the fingers	10021-64999
LC	Left circumflex coronary artery	92978-92984, 92995-92996
LD	Left anterior descending coronary artery	
LT	Left Side	10021-69979
RC	Right coronary artery	92978-92984, 92995-92996
RT	Right Side	10021-69979
TA, T1-T9	Anatomic modifiers which are associated with the toes	10021-64999

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References:

1. American Medical Association, *Coding with Modifiers*
2. American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services
3. Centers for Medicare and Medicaid Services (CMS), Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
4. Centers for Medicare and Medicaid Services (CMS), MLN MM1018 Payment Reduction for X-Rays Taken Using Computed Radiography
5. Centers for Medicare and Medicaid Services, Medicare-Fee-For-Service, Hospital Outpatient PPS, Discarded Drugs and Biologicals – JW Modifier and JZ Modifier Policy, https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf

Revision History

Company(ies)	DATE	REVISION
ConnectiCare	3/26/2025	• Addition of modifier AX and applicable codes to Modifier Reference table **effective 8/01/2025**
ConnectiCare	2/26/2025	• Addition of modifiers JW & JZ to Modifier Reference table
ConnectiCare	2/26/2025	• Transferred policy content to individual company-branded template. No changes to policy title or policy number.
EmblemHealth ConnectiCare	5/18/2023	• Policy updated clarify that Modifier 76 payment reductions do not apply to EH Medicaid Plans
EmblemHealth ConnectiCare	4/25/2023	• Removed note regarding modifier(s) 25 or 59 when reporting a separately identifiable preventive service with HCPCS codes G0442-G0447 and unrelated E/M services. *Added to Medicare Preventive Services Reimbursement Policy*
EmblemHealth ConnectiCare	7/20/2022	• Effective 1/01/2023: Modifiers FX and FY payment reductions updated to align with CMS
EmblemHealth ConnectiCare	2/01/2022	• Updated policy to include 5 new modifiers effective 1/01/2022: 93, FQ, FR, FS & FT
EmblemHealth ConnectiCare	11/2021	• Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number
ConnectiCare	5/2021	• The following modifier payments/payment reductions updated to align with CMS: AS, PA, PB, PC, QE, 22, 52, 54, 55, 56, 62, 63, 78, 80, 81, and 82.