moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM019
Policy Title:	Valid and/or Required Modifier to Procedure Code Combinations		
Section:	Modifiers	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	12/18/2006	Initially Published:	2/26/2013
Last Updated:	4/12/2023	Last Reviewed:	4/12/2023
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		4/12/2023	

Reimbursement Guidelines

A. General

Clinical edits are able to identify whether or not a specific modifier is appropriate to be used in combination with a specific procedure code, and also whether a required modifier is missing from a line item.

B. Valid and Invalid Modifier/Procedure Combinations

1. Our clinical editing system is able to identify a specific list of modifiers that are appropriate to be billed with each five-digit procedure code. Although the procedure code is a valid procedure code and the modifier is a valid modifier, if the procedure and modifier combination is not appropriate to be used together, the line item will deny as an invalid modifier combination. These edits are currently applied to claims billed on CMS1500 and UB04/CMS1450 claim forms.
2. Valid modifier tables are configured based upon:
    a. CMS guidelines, where available, including the Medicare Physician Fee Schedule Database (MPFSDB) modifier indicators.

b. CPT coding guidelines. Where instructions are explicit, CPT notes and guidelines regarding the use of modifiers with a particular code are incorporated.

c. Code definitions and modifier definitions.

d. Clinically derived and/or general claim convention experience.

e. Medical specialty society information.

f. In rare cases discrepancies exist between guidelines from two or more sources listed above. In these situations, Moda Health has sole discretion to determine which guideline to use to determine whether or not a modifier is appropriate to use with a specific procedure code.

3. To remedy an invalid modifier combination denial:

   a. If a line item is denied for an invalid modifier combination, the claim cannot be adjusted based upon a phone call to Customer Service; a corrected claim will be needed. Records may need to accompany the corrected claim in some situations.

   b. If you believe the invalid modifier denial is incorrect, please submit a written provider appeal and include coding guidelines supporting why the procedure code and modifier combination should be considered valid.

4. Specific combination examples:

   a. <u>Example # 1:</u>

      58720 = *Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)*
      This code is already priced as bilateral. Modifier 50 is not a valid modifier with this code. 58720-50 would deny for invalid modifier combination.

   b. <u>Example # 2:</u>

      27506 = *Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws*
      Modifiers LT or RT would be valid for 27506 because there is a Right femur and a Left femur.

   c. <u>Example # 3:</u>

      20552 = *Injection(s); single or multiple trigger point(s), one or two muscle(s)*
      Modifiers LT or RT are not valid for 20552 because trigger points and muscles exist throughout the body, not in only two paired locations.

C. Required Modifier/Procedure Combinations

Our clinical editing system is also able to identify when a modifier or one of a selection of modifiers is required to be billed with a specific procedure code. If a required modifier is missing, a clinical edit denial will occur.

Please note the requirements for modifiers RR, NU, UE in the table located in section D, Modifier-specific Guidelines.

D. Modifier-specific Guidelines

It is impossible to cover every possible modifier and/or combination in this document. However, the following information is offered to help address the most common questions and concerns submitted to Moda Health regarding invalid modifier combination denials or missing required modifier denials.

Modifier(s)	Moda Health Configuration & Reimbursement Guidelines	Examples of combinations which will deny
24, 25	Modifiers 24 and 25 are valid on Evaluation and Management (E/M) procedure codes only.	Do not use modifiers 24 and 25 with surgical codes, medicine procedures, diagnostic tests and procedures, etc.
26	Modifier 26 is considered valid for procedures with a Professional Component (PC)/Technical Component (TC) Indicator of 1 or 6.	Do not use modifier 26 for procedures with a Professional Component (PC)/Technical Component (TC) Indicator of 0, 2, 3, 4, 5, 7, or 9.
TC	Modifier TC is considered valid for procedures with a Professional Component (PC)/Technical Component (TC) Indicator of 1.	Do not use modifier TC for procedures with a Professional Component (PC)/Technical Component (TC) Indicator of 0, 2, 3, 4, 5, 7, 8, or 9.
50	Modifier 50 is considered valid on codes that have a bilateral indicator of 1 and 3. Report as a single line item with units = "1."	Do not use modifier 50 with procedure codes that have a bilateral indicator of 0, 2, or 9 on the Physician Fee Schedule; another modifier should be used or the code is already priced as bilateral.
51	Modifier 51 is considered valid for procedures with a multiple procedure indicator of 2, 3, 4, 5, 6, or 7.	The CMS Physician Fee Schedule indicates that modifier 51 is not eligible to be used with the CMT codes (98940 - 98943). Moda Health will deny 98940 - 98943 for invalid modifier combination when billed with modifier 51.
52	Modifier 52 (reduced services) signifies that only part of the code description was performed, some parts were omitted.	Do not use modifier 52 with: • Evaluation and management codes. • When another code is available to describe a lesser service. • With an all-or-nothing procedure code. • With an unlisted code. (See modifier 52 Reimbursement Policy for more details.)

Modifier(s)	Moda Health Configuration & Reimbursement Guidelines	Examples of combinations which will deny
58	Modifier 58 is considered valid for procedures with a Global Days indicator setting of 000, 010, 090, or ZZZ. Modifier 58 is not considered valid for procedures with a Global Days indicator setting of XXX.	99213-58 will be denied for invalid modifier combination. May not be used with E/M codes. Modifier 58 may not be appended to radiology codes, infusion administration codes, or other non-surgical codes.
78	Modifier 78 is considered valid for procedures with a Global Days indicator setting of 000, 010, 090, or ZZZ. Modifier 78 is not considered valid for procedures with a Global Days indicator setting of XXX.	99213-78 will be denied for invalid modifier combination. May not be used with E/M codes. Modifier 78 may not be appended to radiology codes, infusion administration codes, or other non-surgical codes.
79	Modifier 79 is considered valid for procedures with a Global Days indicator setting of 000, 010, 090, or ZZZ. Modifier 79 is not considered valid for procedures with a Global Days indicator setting of XXX.	99213-79 will be denied for invalid modifier combination. May not be used with E/M codes. Modifier 79 may not be appended to radiology codes, infusion administration codes, or other non-surgical codes.
90	Modifier 90 = Reference (outside) laboratory Valid for laboratory test procedures. By definition, modifier 90 indicates the services described by the procedure code billed with modifier 90 attached were **NOT** performed by the physician or office submitting the claim.	36415-90 will be denied for invalid modifier combination. A drawing fee or venipuncture cannot be referenced out to another lab so modifier 90 should not be reported with CPT code 36415. If the office performs venipuncture (36415) to send the specimen to an outside laboratory for tests, then they have performed the venipuncture, and it is not correct to attach modifier 90 to 36415.

Modifier(s)	Moda Health Configuration & Reimbursement Guidelines	Examples of combinations which will deny
LT, RT	Modifiers LT and RT are only considered valid for procedure codes specific to body parts that exist only twice in the body, once on the left and once on the right (paired body parts). For example, eye procedures (e.g., cataract surgery) and knee procedures (e.g., total knee replacement). Modifiers LT and RT should be used when a procedure was performed on only one side of the body, to identify which one of the paired organs was operated upon. Modifiers LT and RT may not be reported together on the same line. If the service was performed on both sides of the body, modifier 50 is usually appropriate for use. (Moda [F]) If modifier 50 is not appropriate for some reason, report the code with modifier LT on one line item and the code with modifier RT on a separate line item. (CMS[9])	LT and RT are not considered valid for toe procedures, excision of lesions, tendon/ligament injections (20550), or needle placements, etc. (Use finger and toe modifiers for finger and toe procedure codes; use eyelid modifiers for eyelid procedures.) If the code description is for a structure that occurs multiple times on one side of the body (e.g., fingers, tendons, nerves, etc.) and is not specific enough for you to be able to mark on a body diagram where the left or right procedure is performed without looking at the medical record (e.g., place an "x" on the left shoulder for 73030-LT), then LT and RT are not valid modifiers. (Modifier -59 may be needed to indicate a separate lesion, separate nerve, separate tendon, etc. for non-paired procedure codes.) If modifier LT and RT are both reported on the same line item, the modifier combination will deny. (e.g., 31296-LT-RT, A5505-LT-RT x 2 units)
NU, RR, UE	According to the CMS DMEPOS and DMAP fee schedules, specific codes must be billed with modifier NU, others must be billed with modifier RR, and still others must be billed with either NU, RR, or UE. There are also procedure codes that do not require one of these modifiers. If a modifier is required on the contracted fee schedule, Moda Health's Provider Pricing Configuration requires the presence of the correct modifier to correctly price the line item. **Effective 1/1/2021**, If the needed modifier from the contracted fee schedule is missing, the line item will be denied, and a corrected claim will be needed.	A4233 requires modifier NU. If modifier NU is not billed, A4233 will deny for a required modifier is missing. E0296 requires modifier RR. If modifier RR is not billed, E0296 will deny for a required modifier is missing. A4618 requires either modifier NU, RR, or UE. If one of these three modifiers is not used, A4618 will deny for a required modifier is missing.

Modifier(s)	Moda Health Configuration & Reimbursement Guidelines	Examples of combinations which will deny
QW	Modifier QW is considered valid for procedure codes on the CMS list of CLIA waived lab tests	Do not use modifier QW for lab test procedure codes not on the CMS list of CLIA waived procedure codes
SG	Modifier SG = ASC facility service Modifier SG is only valid for surgical codes	**Commercial claims –** Do not use modifier SG with related HCPCS codes for DME, surgical implants, equipment used during the surgery, supplies, drugs, etc. These items are related to the surgery, and in some cases are eligible for separate reimbursement, but they are not facility fees. **Medicare Advantage claims –** Effective 1/1/2008 modifier SG is no longer applicable for Medicare claims (CMS[8]). The valid modifier configuration for Medicare Advantage claims essentially ignores the presence or absence of modifier SG, and Medicare Advantage claims for non-surgical/ancillary procedure codes submitted with modifier SG will *not* deny. **Medicaid claims –** Medicaid rules vary from state to state. Please only use modifier SG with non-surgical/ancillary procedure codes when there is a specific instruction from your state's Medicaid authority to use modifier SG.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")

Acronym or Abbreviation		Definition
HIPAA	=	Health Insurance Portability and Accountability Act
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
UB	=	Uniform Bill

Modifier Definitions:

Modifier	Modifier Description & Definition
Modifier 24	Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period.
Modifier 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
Modifier 26	**Professional Component:** Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier 26 to the usual procedure number.
Modifier TC	**Technical Component:** Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians. However, portable x-ray suppliers only bill for technical component and should utilize modifier TC. The charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.
Modifier LT	Left side (used to identify procedures performed on the left side of the body)
Modifier RT	Right side (used to identify procedures performed on the right side of the body)
Modifier NU	New equipment
Modifier RR	Rental (use the RR modifier when DME is to be rented)
Modifier QW	CLIA waived test
Modifier UE	Used durable medical equipment

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"Modifiers -LT or -RT apply to codes which **identify procedures which can be performed on paired organs**, e.g., ears, eyes, nostrils, kidneys, lungs, and ovaries." (Bolded font added.) (CMS[1])

"Modifiers LT and RT
LT (Left) and RT (Right)
Identifies **procedures performed on paired organs**, e.g., eyes, ears, nostrils, kidneys, etc.

- Used for procedure performed on one side only.
- Identifies which side procedure was done on."

(Bolded font added.) (NHIC, Corp. Medicare Services [2])

"Use modifiers -LT or -RT only when a procedure is performed on one side of the body **and is a paired organ** (e.g. lungs, kidneys, ears or ovaries). Modifiers -LT and -RT should also be used when the procedures performed are similar but not identical **and are both performed on paired body parts.** For example, a patient has a lesion removed from the left breast and a biopsy of a lesion of the right breast. In this instance, assign 19120 with modifier -LT and 19100 with modifier -RT." (Bolded font added.) (Ingenix/Optum[3])

"When a physician does a procedure **on a paired organ**, there is the **possibility** that the coder should use an -RT or -LT modifier to define the side. In general, use a -50 modifier when the physician performs a procedure on both organs in a pair**….** If the lesion was on the left side of the back, that doesn't matter. There is only one back…. Here's an example of an appropriate use for one of these types of modifiers: When you assign a CPT code to the excision of a lesion of the left breast, you appropriately use 19120-LT. **It's a paired organ** and the code allows for use of this class of modifier.**"** (Bolded font added.) (Gold & Krauss[4])

"Modifiers -LT and -RT, meanwhile, designate a procedure the physician performs **on one side of paired organs** (e.g., ears, eyes, kidneys) or, sometimes (as is usually the case in neurology), **paired extremities** (e.g., arms and legs)." (Bolded font added.) (The Coding Institute[5])

"Modifiers LT and RT apply to codes that identify procedures **that can be performed on paired organs** such as ears, eyes, nostrils, kidneys, lungs, and ovaries. Modifier LT (left) and RT (right) are usually applied when a procedure is performed on only one side. ASCs use the appropriate modifier **to identify which one of the paired organs** was operated on. CMS requires these modifiers whenever appropriate." (Bolded font added.) (medicalbillingcptmodifiers.com [6])

"Providers or suppliers shall use anatomic modifiers (e.g., RT, LT, FA, F1-F9, TA, T1- T9, E1-E4) and report procedures **with differing modifiers on individual claim lines** when appropriate. Many MUEs are based on the assumption that correct modifiers are used." (Bolded font added.) (CMS[9])

Cross References

A. "Technical Component (TC), Professional Component (PC/26), and Global Service Billing," Moda Health Reimbursement Policy Manual, RPM008.

B. "Modifiers 58, 78, and 79 – Staged, Related, and Unrelated Procedures," Moda Health Reimbursement Policy Manual, RPM010.

C. "Routine Venipuncture," Moda Health Reimbursement Policy Manual, RPM012.

D. "Modifier 52 – Reduced Services," Moda Health Reimbursement Policy Manual, RPM003.

E. "Modifier 51 - Multiple Procedure Fee Reductions," Moda Health Reimbursement Policy Manual, RPM022.

F. "Modifier 50 – Bilateral Procedure." Moda Health Reimbursement Policy Manual, RPM057.

References & Resources

1. CMS. "Clarification of Modifier Usage in Reporting Outpatient Hospital Services." Transmittal No. A-00-73. October 5, 2000. Accessed November 29, 2011. http://www.cap.org/apps/docs/medicare/program_memorandums/a0073.pdf , http://www.cms.gov/Transmittals/CMSPM/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS052339&intNumPerPage=2000

2. Jeannine Bouchard & Joanne Lespasio. "Hospital Outpatient Modifiers." *NHIC, Corp. Medicare Services.* Publication date February 2010. Accessed November 29, 2011. http://www.medicarenhic.com/PA/billing/02-2010%20Hospital%20Outpatient%20Modifiers.pdf .

3. Ingenix Inc. Staff. "Brush Up on CPT/HCPCS Modifiers." *ADVANCE for Health Information Professionals*. Publication date February 27, 2007. Accessed November 29, 2011. http://health-information.advanceweb.com/Article/Brush-Up-on-CPTHCPCS-Modifiers.aspx.

4. Robert S. Gold, MD, Glenn Krauss, RHIA. "To modify or not to modify? Coding for procedures on paired organs." *DCBA Interactive.* Accessed November 29, 2011. http://www.cditalk.com/content/148-To-modify-or-not-to-modify-Coding-for-procedures-on-paired-organs .

5. "Reader Questions: Use Modifier -50 or -RT/-LT, Not Both." *SuperCoder.com - The Coding Institute*. Accessed November 29, 2011. http://www.supercoder.com/articles/articles-alerts/nca/reader-questions-use-modifier-50-or-rt-lt-not-both/

6. "Most used modifier in ASC – Tips for Modifiers use in an Ambulatory Surgery Center." *medicalbillingcptmodifiers.com*. Published May 30, 2010. Accessed November 29, 2011. http://www.medicalbillingcptmodifiers.com/2010/05/most-used-modifer-in-asc.html

7. Grider, Deborah J. *Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage*. Chicago: AMA Press, 2004.

8. CMS. "Annual Type of Service (TOS) Update." Transmittal No. 1410. January 11, 2008. Last accessed January 3, 2020. Page 5 of 50. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1410CP.pdf .

9. CMS. "Medically Unlikely Edits (MUEs)." Medicare Claims Processing Manual (Pub. 100-4). Chapter 23 – Fee Schedule Administration and Coding Requirements, § 20.9.3.2.

Background Information

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate

specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
4/12/2023	Clarification/Update: Section D: CMS instructions that modifiers LT and RT may not be used together on the same line item added with footnote. Definition of Terms table, & Procedure Code Table: Unused and blank. Removed. Coding Guidelines & Sources: Added CMS quote on modifiers LT & RT must be used on separate line items. Cross References: Hyperlinks added. References & Resources: One entry added.
10/12/2022	Formatting/Update: Change to new header. Includes Idaho. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
2/26/2013	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
12/18/2006	Original Effective Date (with or without formal documentation). Policy based on clinical editing software which uses AMA & CMS coding guidelines.