MASSACHUSETTS

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BCBSMA Processing Guidelines for CPT Modifiers

In accordance with the implementation of the Health Insurance Portability and Accountability Act (HIPAA), if you currently use modifiers in your billing it is essential that you use standard modifiers to describe the service for which you are billing. Modifiers indicate that a service or procedure you've performed has been altered by some specific circumstance, but has not changed in its definition or code.

We require standard modifiers on all claims (paper and electronic) that and will reject claims that use non-standard modifiers**.** This applies only to providers who currently use modifiers in their billing. Please begin using standard modifiers now (where appropriate) so that we can reimburse you promptly for the care you provide to our members.

For your convenience, we've included a table of the most commonly used CPT standard modifiers and BCBSMA's processing guidelines for those modifiers. Please refer to the *HCPCS and CPT Modifier List* document for a complete list of HCPCS and CPT standard modifiers available at www.bluecrossma.com/provider or refer to your CPT and HCPCS manuals.

* **Only certain Claim Check modifiers will impact UB claims processing.**

Modifier	Use for:	To indicate that:	And note that:
N/A	N/A	MOD 21 HAS BEEN DELETED EFFECTIVE 2009	N/A
22	Unusual procedural services	The provided service was SUBSTANTIALLY greater than that usually required for the reported procedure.	The operative report or procedure note is required. We will base reimbursement on procedural services described in the operative report.
23	Unusual anesthesia	A procedure which usually requires no anesthesia or local anesthesia must be performed under general anesthesia..	Reimbursement is not affected by modifier 23.
24	Unrelated E&M service by the same physician during a postoperative period	An E&M service was performed during the postoperative period for a reason(s) unrelated to the original surgical procedure.	An ICD-9-CM diagnosis code unrelated to the diagnosis code reported for the surgical procedure on the claim form is required. .
25*	Significant, separately identifiable E&M service by the same physician on	The patient's condition required a significant, separately identifiable E&M service by the same physician on the same day as another service.	The clinical notes must support a significant, separately identifiably E&M above and beyond the other service provided.

Modifier	Use for:	To indicate that:	And note that:
25…	the same day of the procedure or other service		
26	Professional component	The claim is for the professional component of the reported procedure.	Modifier 26 is required if the claim is for the professional component.
32	Mandated services	The service is related to a mandated consultation or service.	We do not provide additional reimbursement for this modifier.
47	Anesthesia by surgeon	The surgeon provided regional or general anesthesia.	We do not provide separate reimbursement for anesthesia provided by the surgeon.
50	Bilateral procedure	A procedure usually performed on only one side of the body was performed on both sides of the body during the same operative session by the same surgeon.	You should bill the procedure on one line using modifier 50 and one unit of service. Do not use this modifier with codes for which the narrative indicates bilateral.
51	Multiple procedures	Multiple procedures or services(other than E&M and Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines) were rendered at the same session, by the same provider.	We do not provide additional reimbursement for modifier 51.
52	Reduced services	A service or procedure was partially reduced or eliminated at the physician's discretion.	Mod 52 is recognized for certain procedures
53	Discontinued procedure	The physician elected to terminate a surgical or diagnostic procedure due to extenuating circumstances.	Modifier 53 is recognized to report an incomplete colonoscopy.
54	Surgical care only	One physician performs the surgical procedure and another provides preoperative and/or postoperative management. Only the intra-operative portion of the global surgery was performed.	Modifier 54 is recognized to allow reimbursement for the intra-operative portion of the global surgery performed. We will base payment on the intra-operative portion of the global fee as well as the inpatient postoperative services.
55	Postoperative management only	One physician performed the postoperative management and another physician performed the surgical procedure. We will base payment on the **outpatient**	The **surgeon** should ***not*** report modifier 55. The non-surgical physician performing the outpatient postoperative care should report the surgical

Modifier	Use for:	To indicate that:	And note that:
55…		**postoperative portion** of the global fee. When a non-surgical specialist needs to **render inpatient postoperative medical care**, the non-surgical specialist should bill an appropriate level of E&M code and **no modifier.**	procedure code, and modifier 55. ***Do not bill procedure code 99024.*** Report postoperative care after all services has been rendered. The dates of service should indicate the range from the first to the last date of service. The number of units reported should equal the number of services rendered.
56	Preoperative management only	One physician performed the preoperative care and evaluation and another physician performed the surgical procedure.	This modifier is valid only for **major** surgeries *(those with a 90-day global period).*
57	Decision for surgery	An E&M service resulted in the initial decision to perform the surgery.	This modifier is valid only for **major** surgeries.
58	Staged or related procedure or service by the same physician during the postoperative period	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.	Modifier 58 is recognized for certain procedures. For treatment of a problem that requires a return trip to the operating room/procedure room, please see modifier 78.
59	Distinct procedural service	The procedure or services was distinct or independent from other non E&M services performed on the same day.	Modifier 59 is recognized on code combinations according to ClaimCheck editing software. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion or separate injury (or area of injury in extensive injuries)
62	Two surgeons	Two surgeons work together to perform distinct parts of the same surgical procedure.	We will reimburse each surgeon at 62.5 percent of the global surgical fee.
63	Procedure performed on infants	A procedure was performed on neonates and infants up to a present body weight of 4 kg.	Reimbursement is not affected by modifier 63.
66	Surgical team	More than two surgeons simultaneously performed highly complex procedures using a team approach.	The operative report for each is required. We will base reimbursement on the complexity of the surgery

Modifier	Use for:	To indicate that:	And note that:
			described in the operative report.
73	Discontinued Outpatient Hospital or ASC surgical procedures prior to administration of Anesthesia	Due to extenuating circumstances or those that threaten the well being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the preparation(including sedation when provided and being taken to the room where the procedure is being performed), but prior to the administration of anesthesia (local, regional, or general).	The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation. There is no reimbursement for services not performed.
74	Discontinued Outpatient Hospital/ASC surgical procedure after administration of anesthesia	Due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional, general) or after the procedure was started (Incision made, intubation started, scope inserted etc).	The elective cancellation of a service after the administration of anesthesia and/or surgical preparation. Reimbursement is not affected by modifier 74.
76	Repeat procedure or service by same physician	A procedure or service was repeated subsequent to the original procedure or service by the same physician.	Modifier 76 is recognized on certain procedures and services.
77	Repeat procedure by another physician	A basic procedure or service was repeated by another physician other than the one who performed the original procedure or service.	Modifier 77 is recognized on certain procedures and services.
78	Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period	Another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following the initial procedure). It is related to the first procedure/surgery and requires the use of an operating/procedure room.	Modifier 78 is recognized on surgical procedures.
79	Unrelated procedure or	The performance of a procedure or service during the	Modifier 79 is recognized on surgical procedures.

Modifier	Use for:	To indicate that:	And note that:
79…	service by the same physician during the postoperative period	postoperative period was unrelated to the original procedure.	
80	Assistant surgeon	A surgical assistant provided services.	We provide reimbursement for a surgical assistant based on 16 percent of the global surgical fee. Use modifier 80 only with procedures that warrant an assistant.
81	Minimum assistant surgeon	A surgical assistant provided minimal services.	We provide reimbursement for a surgical assistant based on 16 percent of the global surgical fee. Use modifier 81 only with procedures that warrant an assistant.
82	Assistant surgeon (when qualified resident surgeon not available)	A surgical assistant provided services because a qualified resident surgeon was not available.	We provide reimbursement for a surgical assistant based on 16 percent of the global surgical fee. Use modifier 82 only with procedures that warrant an assistant.
90	Reference (outside) laboratory	Laboratory procedures are performed by a party other than the treating or reporting physician.	Modifier 90 indicates that a party other the treating or reporting party performed a particular procedure.
91	Repeat clinical diagnostic laboratory test	It may be necessary to repeat the same laboratory test on the same day to obtain subsequent test results.	Reimbursement is not affected by modifier 91. Do not use this modifier when tests are rerun to confirm initial results; due to testing problems with specimens and/or equipment; or for any other reason when a normal, one-time reported result is all that is required.
92	Alternative laboratory platform testing	Laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber.	Reimbursement is not affected by modifier 92.
99	Multiple modifiers	Two or more modifiers may be necessary to completely delineate a service.	Reimbursement is not affected by modifier 99. Other applicable modifiers may be listed as part of the description of service.