



MODIFIERS – Professional Claims

Blue Cross and Blue Shield of Texas/HMO Blue Texas accept all valid CPT and HCPCS modifiers into the claims processing systems.

The following modifiers have logic associated with them that might impact the claim.

Modifier 22: Denotes an unusual procedural service. Should only be submitted on surgical procedure codes along with supporting documentation to justify the unusual service:

- ✓ If documentation supports sufficient difficulty/complexity to warrant additional payment for a procedure submitted with Modifier -22, then 25% of the eligible amount is allowed as an additional payment.
- ✓ Otherwise, no additional payment is allowed.
- ✓ *A provider is allowed one appeal if the initial request for recognition of Modifier -22 is denied.*

Modifier 25: Denotes a significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service. Should only be submitted on an evaluation and management code, and medical records should reflect the significant, separately identifiable service.

Modifier 50: Denotes a bilateral procedure. This modifier should be submitted only for those surgical procedures that can be performed bilaterally. See Multiple Surgery document or Surgery Introduction, SUR701.000 in the Medical Policy Manual for more information on bilateral procedures.

Modifier 57: Denotes decision for surgery. This modifier will be allowed when appended to an Evaluation and Management code either 1 day prior OR same day as a MAJOR (90 day global) surgical procedure. Please follow CMS guidelines for global days, as listed in the CMS Physician Fee Schedule.

Modifier 59: Denotes distinct procedural service. This modifier will be allowed when appended to procedures or service that are not routinely reported together. Please follow CPT guidelines as outlined in Appendix A of the current year CPT Manual.

Modifier 62: Denotes two surgeons working together as primary surgeons. Both surgeons should submit this modifier on only those services where they are acting as primary surgeons. See Co-Surgery, SUR701.002 in the Medical Policy Manual for more information. NOTE: Physicians acting as co-surgeons cannot bill as assistants.

Modifier 66: Denotes surgical team. See modifier 62 above.

Home Infusion Therapy Providers Only:

Modifier SH: Denotes second concurrently administered infusion therapy. Services submitted with this modifier will be allowed at 50% of the eligible amount.

Modifier SJ: Denotes third concurrently administered infusion therapy. Services submitted with this modifier will not be reimbursed.

Repeat Procedures

Modifier 76: Denotes a repeat procedure by the **same** physician. Should be submitted only when a procedure is repeated on the same date of service by the **same** physician

Modifier 77: Denotes a repeat procedure by **another** physician. Should be submitted only when a procedure is repeated on the same date of service by **another** physician

NOTE for Modifiers 76 and 77: The procedure must be the same procedure. It is submitted on the claim form once and then listed again with the appropriate modifier.

Assistant Surgeon Modifiers

Modifier 80, 81, 82: Denote assistant surgeons. Should be submitted on those surgical procedures where an assistant surgeon is warranted. NOTE: Physicians acting as assistants cannot bill as co-surgeons. Benefits will be derived based on CMS designation for Assistant Surgeon.

Supervision of Physician Assistant, Advanced Practice Nurse or Certified Registered Nurse First Assistant

The following modifiers should be used by the supervising physician when he/she is billing for services rendered by a Physician Assistant (PA), Advanced Practice Nurse (APN) or Certified Registered Nurse First Assistant (CRNFA):

AS Modifier: A physician should use this modifier when billing on behalf of a PA, APN or CRNFA for services provided when the aforementioned providers are acting as an assistant during surgery. (Modifier AS to be used *ONLY* if they assist at surgery)

SA Modifier: A supervising physician should use this modifier when billing on behalf of a PA, APN, or CRNFA for **non-surgical** services. (Modifier SA is used when the PA, APN, or CRNFA is assisting with any other procedure that *DOES NOT* include surgery.)

-80 Modifier: PA's, APN's, and CRNFA's who are billing with their own National Provider Identifier (NPI) will not need to bill a modifier, unless they are billing as an Assistant Surgeon, then they must use the -80 modifier.

Technical and Professional Components

Modifiers 26 and TC: Modifier 26 denotes professional services for lab and radiological services. Modifier TC denotes technical component for lab and radiological services. These modifiers should be utilized on the appropriate lab and radiological procedures only, and are inherent in provider fee schedules.

NOTE: When a provider performs both the technical and professional service for a lab or radiological procedure, he/she must submit the **total** service, not each service individually.

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