BlueCross BlueShield of Texas

Modifier 25 and Modifier 59 Frequently Asked Questions (FAQ)

Blue Cross and Blue Shield of Texas (BCBSTX) uses coding guidelines set forth by the American Medical Association – Complete Procedural Terminology (CPT) and CMS NCCI (National Correct Coding Initiative). BCBSTX will deny a claim when modifiers 25 or 59 appear to be incorrectly used. For example, if modifier 59 is used with an evaluation and management code, it will be denied. A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in the definition of the code. Current claims code processing logic validates the modifiers that are appended to a claim by comparing the submitted combination to valid code combinations as well as the member's prior claims history.

Q: What is modifier 25?

A: *As described by CPT:* Modifier 25 is used to denote a "significant, separately identifiable evaluation and management (E/M) service by the same physician on the same day of the procedure or other service." Modifier 25 should only be submitted on an E/M code. The medical records should reflect the significant, separately identifiable service. Physicians and providers should consult the CPT Manual for details regarding code combinations in addition to CMS NCCI edits.

Q: What is modifier 59?

A: *As described by CPT:* **"**Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together that may be appropriate under certain circumstances. 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) not ordinarily encountered or performed on the same day by the same individual." Please follow CPT guidelines as outlined in the current year's CPT Manual in addition to CMS NCCI edits.

Q: What happens if I submit a claim using modifier 25 or modifier 59?

A: Current and historical member claims data will be reviewed to determine if the modifier can be validated. The use of the modifier will be reviewed against the standards described above. If a CPT/HCPCS (Healthcare Common Procedure Coding System) code is denied, a provider has the opportunity to submit medical records for reconsideration of the denied code(s). This can be done utilizing the Claim Inquiry Resolution (CIR) tool on Availity® or utilizing the Claim Review Form which can be found on the BCBSTX provider website.

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Modifier 25 and Modifier 59 Frequently Asked Questions (FAQ), cont'

Q: When did BCBSTX implement code editing software for modifier validation?

A: In November 2017, modifier validation edits were added into our claims processing logic with the implementation of Verscend Clinical Validation.

Q: Are there any useful links on BCBSTX website?

A: Yes, the BCBSTX Provider website has additional links to support correct claims billing using modifiers 25 and 59. Refer to the General Reimbursement Information under Standards and Requirements.

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