

	Modifiers	
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NOTICE

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PROVIDER/ENTITY IMPACTED					
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
PROFESSIONAL	FACILITY	DME	AMBULATORY SURGERY	LAB	OTHER

LINES OF BUSINESS IMPACTED						
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
COMMERCIAL	BLUE MEDICARE ADVANTAGE	ACA QHP¹	SMALL GROUP ACA	JAA²	FEP³	DENTAL

¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.

Description/Application

Modifiers indicate that a service was altered in some way from the stated descriptor without changing the definition. The American Medical Association (AMA) modifiers are two-digit alpha/numeric codes listed after a procedure or supply code and separated from the code by a hyphen (e.g., 92506-22).

Documentation may be needed to confirm the validity of the billed modifier before payment is made.

Policy

Blue KC reimburses contracted health care providers for medically necessary services with appropriate modifier use.

Coding

Below is a list of modifiers most often received by Blue KC; however, it is not an all-inclusive list. Documentation may be needed to confirm the validity of the billed modifier. Clinical editing (sub setting, redundant, etc.) may still apply.

MODIFIER	MODIFIER DESCRIPTION	PRICING/FUNCTIONALITY
22	Increased Procedural Services	<ul style="list-style-type: none"> ▪ Modifier 22 is used to indicate that a procedure was complicated, complex, difficult, or took significantly more time than usually required by the physician or practitioner to complete the procedure. Documentation must support the use of modifier 22. ▪ Multiple surgery guidelines may apply.
23	Unusual Anesthesia	<ul style="list-style-type: none"> ▪ Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, must be done under general anesthesia due to unusual circumstances. ▪ Reimbursement is 100% of the 5-digit allowable. ▪ Modifier 23 should be used on basic service procedure codes (00100 - 01999). ▪ Documentation explaining the need for general anesthesia may be required.
24	Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period	<ul style="list-style-type: none"> ▪ Modifier 24 allows the physician to report a service performed during a postoperative period for reason(s) unrelated to the original procedure. ▪ The postoperative period for a major surgery (90 days) includes all routine care of the patient for surgery related services. ▪ Do not use this modifier with a CPT surgical code. Assign the proper E/M code for the service rendered. ▪ Documentation must demonstrate that the care being provided during the inpatient stay following surgery is not related to the surgery.
25	Significant Separately Identifiable Evaluation and Management Service by the Same physician	<ul style="list-style-type: none"> ▪ On the day a procedure or service was performed, the patient's condition required a significant, separately identifiable E/M service beyond the other service provided. ▪ Procedures identified by a CPT code include the evaluation services necessary prior to the performance of the procedure. Examples may include (but are not limited to), <ul style="list-style-type: none"> ○ assessing the site/condition of the problem area ○ explaining the procedure, ○ obtaining informed consent including discussing risks, alternatives, benefits, etc.). ▪ BCBSKC may request medical records to conduct pre-payment and post-payment audits to justify the use of modifier 25. If records indicate that

		based on CPT definition, the modifier is not justified, a denial/refund of payment may be requested.
26	Professional Component	<ul style="list-style-type: none"> ▪ Modifier 26 represents the physician’s supervision and interpretation portion of a service. ▪ Services with a value of “1” or “6” in the PC/TC Indicator field of the National Physician Fee Schedule may be billed with modifier 26. ▪ It is not correct to append both modifier TC and 26 when a global service has been performed. In that case, no modifier should be used. ▪ Modifier 26 should be billed in the first modifier position. ▪ The interpretation of the test/study must be separate, distinct, identifiable, written, and signed. ▪ Modifier 26 is not to be used for a re-read of results of an interpretation initially provided by another physician.
32	Mandated Services	<ul style="list-style-type: none"> ▪ Services related to mandated consultation and/or related services (e.g., third party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure. ▪ This code should not be used when a patient or family member requests a second opinion from another physician.
33	Preventive Services	<ul style="list-style-type: none"> ▪ When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. ▪ For separately reported services specifically identified as preventive, the modifier should not be used.
47	Anesthesia by Surgeon	<ul style="list-style-type: none"> ▪ Anesthesia provided by the surgeon is included in the global allowance for the surgical procedure. No additional allowance is made for the use of modifier 47.
50	Bilateral Procedures	<ul style="list-style-type: none"> ▪ Used to report bilateral procedures performed in the same operative session. ▪ Do not use modifier with surgical procedures identified by their terminology as "bilateral."
51	Multiple Procedures	<ul style="list-style-type: none"> ▪ BCBSKC does not require nor recommend the use of the 51 modifier. The claims payment system recognizes multiple procedures without the use of the 51 modifier. Use of the 51 modifier does not alter clinical editing or subset arrangements.
52	Reduced Services	<ul style="list-style-type: none"> ▪ When a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional, that service can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. ▪ This modifier would also be used to identify a procedure performed unilaterally which is defined by CPT as a bilateral procedure. ▪ Multiple surgery guidelines may apply. ▪ Use of this modifier will result in reduced payment per CMS guidelines .
53	Discontinued Procedure	<ul style="list-style-type: none"> ▪ When the physician elects to terminate a surgical or diagnostic procedure, due to extenuating circumstances or those that threaten the well - being of the patient, it may be necessary to indicate that a surgical

		<p>or diagnostic procedure was started but discontinued. This service can be identified by the addition of modifier 53 to the procedure code.</p> <ul style="list-style-type: none"> ▪ This modifier is not used to report the elective cancellation of a procedure prior to inducing anesthesia and/or surgical preparation in the operating suite. ▪ Multiple surgery guidelines may apply. ▪ Use of this modifier will result in reduced payment per CMS guidelines
54	Surgical Care Only	<ul style="list-style-type: none"> ▪ When 1 physician or other qualified health care professionals perform a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number. ▪ Multiple surgery guidelines may apply. ▪ Use of this modifier will result in reduced payment per CMS guidelines <p>For more detailed information please see Blue KC Payment Policy POL-PP-106 Global Surgical Package</p>
55	Postoperative Management only	<ul style="list-style-type: none"> ▪ When 1 physician or other qualified health care professionals performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number. ▪ Use of this modifier will result in reduced payment per CMS guidelines <p>For more detailed information please see Blue KC Payment Policy POL-PP-106 Global Surgical Package</p>
56	Preoperative Management Only	<ul style="list-style-type: none"> ▪ When 1 physician or other qualified health care professionals perform the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number. ▪ Blue KC requests the physician or practitioner to use the appropriate level E/M code instead of the modified surgery or medicine code. ▪ Use of this modifier will result in reduced payment per CMS guidelines <p>For more detailed information please see Blue KC Payment Policy POL-PP-106 Global Surgical Package</p>
57	Decision for Surgery	<ul style="list-style-type: none"> ▪ An evaluation and management service that resulted in the initial decision to perform major surgery may be identified by adding modifier 57 to the appropriate level of E/M service. ▪ Major surgery is defined as surgery that has a 90-day global period.
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period	<ul style="list-style-type: none"> ▪ The physician may need to indicate that the performance of a procedure or service during the postoperative period was: <ul style="list-style-type: none"> ○ Planned prospectively at the time of the original procedure (staged) ○ More extensive than the original procedure; or ○ Therapy following a diagnostic surgical procedure ▪ Multiple surgery guidelines may apply.
59	Distinct Procedural Service	<ul style="list-style-type: none"> ▪ Modifier 59 is used to identify procedures/services, other than E/M services, which are not normally reported together, but are appropriate under the circumstances.

		<ul style="list-style-type: none"> ▪ This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injury) not ordinarily encountered or performed on the same day by the same physician. ▪ Blue KC will determine the appropriateness of the modifier based on the clinical information submitted to support its use.
62	Two Surgeons	<ul style="list-style-type: none"> ▪ Under certain circumstances, two surgeons (usually of different specialties) may function simultaneously as primary surgeons performing distinct parts of a total surgical service. ▪ Blue KC follows Medicare guidelines for allowable code and modifier combinations. ▪ Co surgery claims should be submitted with both surgeons using modifier 62 on each appropriate line-item code. ▪ Multiple surgery reductions may apply. ▪ Use of this modifier will result in reduced payment per CMS guidelines
63	Procedure Performed on Infants less than 4 kg	<ul style="list-style-type: none"> ▪ Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure code. ▪ It should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory or Medicine sections of the CPT Coding Manual. ▪ Modifier 63 should not be reported on procedures performed on a fetus.
66	Surgical Team	<ul style="list-style-type: none"> ▪ Under certain circumstances, complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, often of different specialties, plus other highly skilled, specially trained personnel, diverse types of complex equipment) are carried out under the "surgical team" concept. ▪ Such circumstances may be identified by each participating individual with the addition of modifier 66 to the basic procedure number used for reporting services. ▪ Documentation should support medical necessity.
76	Repeat Procedure by Same Physician	<ul style="list-style-type: none"> ▪ It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. ▪ Use this modifier to identify the procedure as a repeat rather than a duplicate service or billing error. ▪ This modifier should not be appended to an E/M service.
77	Repeat Procedure by Another Physician	<ul style="list-style-type: none"> ▪ Modifier 77 indicates that a basic procedure or service performed by one physician has been repeated by a second physician. ▪ The second physician adds the modifier to the procedure code used by the first physician. ▪ This modifier should not be appended to an E/M service.

<p>78</p>	<p>Return to the Operating Room for a Related Procedure During the Postoperative Period</p>	<ul style="list-style-type: none"> ▪ This modifier indicates that another related procedure requiring the operative room was performed during the postoperative period of the initial procedure. ▪ A new postoperative period does not begin with the use of the 78 modifier. ▪ Do not use modifier 78 when the original surgery is repeated or when the repeat procedure is not performed in the operating room. ▪ Use of this modifier will result in reduced payment per CMS guidelines
<p>79</p>	<p>Unrelated Procedure or Service by the Same Physician During the Postoperative Period</p>	<ul style="list-style-type: none"> ▪ Modifier 79 indicates that an unrelated procedure or service was performed during a postoperative period of another procedure. ▪ Diagnosis codes must document the medical necessity of the service since the diagnosis for this service differs from those reported with the initial procedure.
<p>80</p>	<p>Assistant Surgeon</p>	<ul style="list-style-type: none"> ▪ Blue KC follows CMS status codes for validity of Assistant Surgeon. <ol style="list-style-type: none"> i. Status 0 Payment restrictions for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity ii. Status 1 Statutory payment restrictions for assistants at surgery applies to this procedure. Assistant at surgery may not be paid. iii. Status 2 Payment restrictions for assistants at surgery do not apply to this procedure. Assistant at surgery may be paid. iv. Status 9 Assistant at surgery concept does not apply ▪ Provides full assistance to the primary surgeon and can take over the surgery should the primary surgeon become incapacitated. ▪ Documentation is required in the body of the operative report that describes what the assistant did. ▪ Blue KC will deny claims if the surgeon does not document what was performed by the assistant. ▪ Modifier 80 should only be applied when a physician performs as an assistant on a surgical service. ▪ Multiple surgery guidelines may apply. ▪ Use of this modifier will result in reduced payment per CMS guidelines.
<p>81</p>	<p>Minimum Assistant Surgeon</p>	<ul style="list-style-type: none"> ▪ Blue KC follows CMS status codes for validity of Assistant Surgeon. <ol style="list-style-type: none"> if. Status 0 Payment restrictions for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity ii. Status 1 Statutory payment restrictions for assistants at surgery applies to this procedure. Assistant at surgery may not be paid. iii. Status 2 Payment restrictions for assistants at surgery do not apply to this procedure. Assistant at surgery may be paid. iv. Status 9 Assistant at surgery concept does not apply ▪ A minimum surgical assistant is an assistant who does not take part in the entire procedure but provides minimal assistance to the primary surgeon. ▪ Documentation is required in the body of the operative report that describes what the assistant did. ▪ Use of this modifier will result in reduced payment per CMS guidelines

<p>82</p>	<p>Assistant Surgeon (When qualified resident surgeon not available)</p>	<ul style="list-style-type: none"> ▪ The unavailability of a qualified resident surgeon is a prerequisite for the use of modifier 82. ▪ Blue KC follows CMS status codes for validity of Assistant Surgeon. <ul style="list-style-type: none"> a. Status 0 Payment restrictions for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity ii. Status 1 Statutory payment restrictions for assistants at surgery applies to this procedure. Assistant at surgery may not be paid. iii. Status 2 Payment restrictions for assistants at surgery do not apply to this procedure. Assistant at surgery may be paid. iv. Status 9 Assistant at surgery concept does not apply ▪ Documentation is required in the operative report that describes what the assistant did. ▪ It is not sufficient evidence of participation to list the assistant’s name in the heading of the operative report. ▪ We require operative notes to contain sufficient information to support the medical necessity of an assistant in surgery. ▪ Use of modifier 82 needs a statement in the documentation that "no qualified resident surgeon was available." ▪ Use of this modifier will result in reduced payment per CMS guidelines
<p>90</p>	<p>Reference (Outside) Laboratory</p>	<ul style="list-style-type: none"> ▪ When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.
<p>91</p>	<p>Repeat Clinical Diagnostic Laboratory Test – Used to indicate a test was repeated on the same day to obtain subsequent (multiple) test results</p>	<ul style="list-style-type: none"> ▪ When it is necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results add modifier 91 to the appropriate CPT code. ▪ This modifier may not be used when tests are rerun to confirm initial results. ▪ This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.
<p>99</p>	<p>Multiple Modifiers</p>	<ul style="list-style-type: none"> ▪ Modifier 99 is used when two or more modifiers may be necessary to completely delineate a service. This modifier is not necessary since the claims editing system accepts multiple modifiers on the same line.
<p>AA</p>	<p>Anesthesia Services Performed Personally by an Anesthesiologist</p>	<ul style="list-style-type: none"> ▪ Anesthesia performed by an anesthesiologist. ▪ Reimbursement is 100% of anesthesia pricing guidelines.
<p>AD</p>	<p>Medical Supervision by a Physician, More Than Four Concurrent Anesthesia Procedures</p>	<ul style="list-style-type: none"> ▪ The AD modifier is used when the anesthesiologist is involved in conducting more than four procedures concurrently. ▪ Anesthesiologist may perform other services while medically directing concurrent procedures. ▪ The anesthesiologist cannot leave the operating suite for anything other than short durations and must be immediately available for the needs of the surgical patient.
<p>AS</p>	<p>Assistant at Surgery</p>	<ul style="list-style-type: none"> ▪ Blue KC follows CMS status codes for validity of Assistant Surgeon. <ul style="list-style-type: none"> i. Status 0 Payment restrictions for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity

		<ul style="list-style-type: none"> ii. Status 1 Statutory payment restrictions for assistants at surgery applies to this procedure. Assistant at surgery may not be paid. iii. Status 2 Payment restrictions for assistants at surgery do not apply to this procedure. Assistant at surgery may be paid. iv. Status 9 Assistant at surgery concept does not apply <ul style="list-style-type: none"> ▪ Clinical nurse specialists, nurse practitioners, and physician assistants may be reimbursed for serving as an assistant during surgery. ▪ Documentation is required in the body of the operative report that describes what the assistant did. It is not sufficient evidence of participation to list the assistant’s name in the heading of the operative report. ▪ Blue KC requires operative notes to contain sufficient information to support the medical necessity of an assistant in surgery. ▪ Use of this modifier will result in reduced payment per CMS guidelines.
AT	Acute Treatment	<ul style="list-style-type: none"> ▪ This modifier is submitted with chiropractic treatment codes 98940, 98941, and 98942. ▪ A chiropractor must place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. ▪ Claims without the AT modifier will be considered as maintenance therapy.
CC	Procedure Code Change	<ul style="list-style-type: none"> ▪ Use CC to indicate the procedure code submitted was changed for administrative reasons or due to an incorrect code initially filed. ▪ Supporting documentation (office notes, operative report, etc.) must accompany a procedure code change.
CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant	<ul style="list-style-type: none"> ▪ This modifier is to be used when a service in whole or in part is furnished by an occupational therapy assistant. ▪ CO modifier is to be used in conjunction with modifier GO.
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant	<ul style="list-style-type: none"> ▪ This modifier is to be used when a service in whole or in part is furnished by a physical therapy assistant. ▪ CQ modifier is to be used in conjunction with modifier GP.
CT	Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA)	<ul style="list-style-type: none"> ▪ Codes submitted with modifier CT will result in a reduced pay per CMS guidelines
E1 E2 E3 E4	Upper left eyelid Lower left eyelid Upper right eyelid Lower right eyelid	<ul style="list-style-type: none"> ▪ Anatomic modifier designates the area or part of the body on which the procedure is performed. ▪ Multiple surgery guidelines may apply.
FA F1 F2	Left hand thumb Left hand, 2nd digit Left hand, 3rd digit	<ul style="list-style-type: none"> ▪ Anatomic modifier designates the area or part of the body on which the procedure is performed. ▪ Multiple surgery guidelines may apply.

F3 F4 F5 F6 F7 F8 F9	Left hand, 4th digit Left hand, 5th, digit Right hand, thumb Right hand 2nd digit Right hand 3rd digit Right hand 4th digit Right hand 5th digit	<ul style="list-style-type: none"> When billing for multiple procedures on multiple digits or for the same procedure on multiple digits enter each digit on a separate line on the claim form rather than attaching multiple modifiers to the same code (e.g., 26428-F6 -F7 -F8).
GN	Services delivered under an outpatient speech language pathology plan of care	<ul style="list-style-type: none"> This modifier is only reported when the service is performed as a part of the therapy plan of care These services are "sometimes therapy" codes that can be performed by non-therapists Report this modifier only when a qualified therapist performs the service.
G0	Services delivered under an outpatient occupational therapy plan of care	<ul style="list-style-type: none"> This modifier is only reported when the service is performed as a part of the therapy plan of care. These services are "sometimes therapy" codes that can be performed by non-therapists. Report this modifier only when a qualified therapist performs the service.
GP	Services delivered under an outpatient physical therapy plan of care	<ul style="list-style-type: none"> This modifier is only reported when the service is performed as a part of the therapy plan of care. These services are "sometimes therapy" codes that can be performed by non-therapists. Report this modifier only when a qualified therapist performs the service.
LT RT	Left side. Right side	<ul style="list-style-type: none"> LT and RT are anatomic modifiers used to identify what side of the body a procedure is performed on.
P1	A normal healthy patient	<ul style="list-style-type: none"> No additional reimbursement
P2	A patient with a mild systemic disease	<ul style="list-style-type: none"> No additional reimbursement
P3	A patient with severe systemic disease	<ul style="list-style-type: none"> No additional reimbursement
P4	A patient with severe systemic disease that is a constant threat to life.	<ul style="list-style-type: none"> No additional reimbursement
P5	A moribund patient who is not expected to survive without the operation.	<ul style="list-style-type: none"> No additional reimbursement
P6	A patient declared brain dead	<ul style="list-style-type: none"> No additional reimbursement
PN	Nonexcepted items and services provided at off-campus provider-based outpatient departments of a hospital	<ul style="list-style-type: none"> You must report facility location for an off-campus, outpatient, provider-based department of a hospital in the 2310E loop of the 837 institutional claim transaction.
QK Pricing rule (EFFECTIVE 1/1/2020)	Medical direction of 2, 3, or 4 Concurrent Anesthesia Procedures Involving Qualified Individuals.	<ul style="list-style-type: none"> Blue KC follows CMS guidance for QK modifier

QS (EFFECTIVE 1/1/2020)	Monitored Anesthesiology Care Service	<ul style="list-style-type: none"> Blue KC follows CMS guidance for QS modifier
QX (EFFECTIVE 1/1/2020)	Qualified nonphysician anesthetist with medical direction by a physician.	<ul style="list-style-type: none"> Blue KC follows CMS guidance for QX modifier
QY (EFFECTIVE 1/1/2020)	Medical direction of one qualified nonphysician anesthetist by an anesthesiologist.	<ul style="list-style-type: none"> Blue KC follows CMS guidance for QY modifier
QZ	CRNA Service without Medical Direction by a Physician	<ul style="list-style-type: none"> Blue KC follows CMS guidance for QZ modifier
RR	DME Rental	<ul style="list-style-type: none"> Use the RR modifier when DME is rented
SH	Second Concurrently Administered Infusion Therapy	<ul style="list-style-type: none"> When multiple home infusions are administered, use modifiers -SH and -SJ.
SJ	Third or More Concurrently Administered Infusion Therapy	
TA T1 T2 T3 T4 T5 T6 T7 T8 T9	LT foot great toe LT foot 2nd digit LT foot 3rd digit LT foot 4th digit LT foot 5th digit RT foot great toe RT foot 2nd digit RT foot 3rd digit RT foot 4th digit RT foot 5th digit	<ul style="list-style-type: none"> Anatomic modifiers to designate the area or part of the body on which the procedure is performed. Multiple surgery guidelines may apply. When billing for multiple procedures on multiple digits or for the same procedure on multiple digits enter each digit on a separate line on the claim form rather than attaching multiple modifiers to the same code (e.g., 28285-T6 -T7 -T8).
TC	Technical Component Only	<ul style="list-style-type: none"> Add modifier TC to a procedure code when billing for the technical component alone. Appropriate for procedures with "1" in the PC/TC field on the Medicare Physician Fee Schedule Database (MPFSDB) Technical component procedures cannot be billed separately by the physician when the patient is: <ul style="list-style-type: none"> Inpatient Outpatient In a covered Part A stay in a skilled nursing facility (SNF) location

References and Resources

Centers for Medicare and Medicaid Services

American Medical Association

Related Documents

Blue KC Payment Policy POL-PP-240 Bilateral Procedures

Blue KC Payment Policy POL-PP-242 Modifier AS Assistant Surgeon

Blue KC Payment Policy POL-PP-106 Global Surgical Package

Blue KC Payment Policy POL-PP-247 Modifiers 59, XE, XP, XS, & XU

Blue KC Payment Policy POL-PP-224 Increased Procedural Services (Modifier 22)

Blue KC Payment Policy POL-PP-234 JW and JZ Modifiers

Revision History

Version	Date	Summary of Revisions
001	8/25/2020	Initial version
002	6/1/2021	Removed Medicare Modifiers and added documentation requirements for Assistant surgeon.
003	7/1/2021	Annual Review, there were no updates or changes made to this policy
004	8/25/2021	Added therapy modifiers CO, CQ, GN, GO, and GP
005	10/29/2021	Removed statement "If a non-therapist performs the service do not report this modifier" from modifier GN, GO, and GP. Added modifier AT acute treatment.
006	12/16/2021	Added information on asst surgeon modifiers AS, 80, 81, and 82, Blue KC follows CMS status codes for validity of Assistant Surgeon
007	12/21/2021	Re-added modifier SH and SJ (removed 6/1/2021)
008	12/30/2021	Added no additional reimbursement for anesthesia physical status modifiers, added to anesthesia modifiers QK, QS, QX QY, and QZ Blue KC follows CMS guidance
009	6/9/2022	Removed Technical component charges are institutional charges and not billed separately by physicians. Added Appropriate for procedures with "1" in the PC/TC field on the Medicare Physician Fee Schedule Database (MPFSDB), Technical component procedures cannot be billed separately by the physician when the patient is: Inpatient, Outpatient, in a covered Part A stay in a skilled nursing facility (SNF) location.
010	8/11/2022	Annual review, Removed % of payment for AS, 80, 81, 82, and additional pricing modifiers.
011	8/1/2023	Annual review, added under modifiers 50 and LT, RT link to Bilateral Payment Policy.
012	3/5/2024	For modifiers TA-T9 and FA-F9 added " When billing for multiple procedures on multiple digits or for the same procedure on multiple digits enter each digit on a separate line on the claim form rather than attaching multiple modifiers to the same code (e.g., 28285-T6 -T7 -T8).
013	5/6/2024	Added percentage of allowed amount to be paid for reduced service and post-op modifiers 52, 53, 54, 55, 56 and 78
014	5/14/2024	Added Modifier CT to policy
015	6/11/2024	Removed percentage reduction from policy and added statement "Use of this modifier will result in reduced payment per CMS guidelines."

016	8/25/2024	Annual review, added links to other modifier policies throughout policy
017	1/14/2025	Modifier PN add to policy
018	8/25/2025	Annual review, no changes, or updates were added to this policy