blue of california

Payment Policy

Modifier Reimbursement	
Original effect date:	Revision date:
01/01/2002	01/01/2022

IMPORTANT INFORMATION

Blue Shield of California payment policy may follow industry standard recommendations from various sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT) and/or other professional organizations and societies for individual provider scope of practice or other coding guidelines. The above referenced payment policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms or their electronic equivalent. This information is intended to serve only as a general reference regarding Blue Shield's payment policy and is not intended to address every facet of a reimbursement situation. Blue Shield of California may use sound discretion in interpreting and applying this policy to health care services provided in a particular case. Furthermore, the policy does not address all payment attributes related to reimbursement for health care services provided to a member. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy such as coding methodology, industry - standard reimbursement logic, regulatory/legislative requirements, benefit design, medical and drug policies. Coverage is subject to the terms, conditions and limitation of an individual member's programs benefits.

Application

Blue Shield follows industry standard coding and reimbursement guidelines pertaining to the application, claims processing, and reimbursement of CPT and HCPCS modifiers.

Modifier reductions noted below will apply on top of any other reduction(s) that may apply, such as Multiple Surgery, Multiple Endoscopy, Multiple Therapy and/or other payment modifiers adjustments.

Policy

The following is a list of modifiers that Blue Shield will apply for claims processing and reimbursement methodology.

Modifier	Description	Processing logic
22	Increased procedural services	Pend for Medical Review. Medical records may be required. 120% of allowance
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period	Override 'Bundling' edits when billed according to AMA CPT coding guidelines.
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	Override 'Bundling' edits when billed according to AMA CPT coding guidelines.
26	Professional Component	Reduced allowance for professional component.
32	Mandated Services	Identify and process the claims for mandated services Modifier 32 is required to identify and process the claims for ***COVID-19 testing for Essential Workers***. **Note**: This arrangement is valid until the earlier of **(a)** the expiration of the DMHC emergency regulation on COVID-19 Diagnostic Testing (1/14/2021, unless extended) or **(b)** the end of the California PHE (Public Health Emergency).
50	Bilateral Procedures	CPT / HCPCS codes that have Modifier 50 appended, or when there are procedure/surgery code descriptions that are defined as bilateral procedures/surgeries by their code description, will be reimbursed with the first procedure at 100% and the second procedure at 50% of the Blue Shield Provider Allowance.
52	Reduced Services	50% of allowance
53	Discontinued Procedure	50% of allowance
54	Surgical Care only	Reimbursement is based on the Intraoperative Percentage Indicator value as defined by the CMS Physician Fee sched ule multiplied by the Blue Shield Provider Allowance.
55	Post-Operative Management only	Reimbursement is based on the Postoperative Percentage Indicator value as defined by the CMS Physician Fee sched ule multiplied by the Blue Shield Provider Allowance.
56	Preoperative Management only	Reimbursement is based on the Preoperative Percentage Indicator value as defined by the CMS Physician Fee sched ule multiplied by the Blue Shield Provider Allowance.
57	Decision for Surgery	Override 'Bundling' edits when billed according to AMA CPT coding guidelines.
58	Stag ed or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	Override 'Bundling' edits when billed according to AMA CPT coding guidelines.
59	Distinct Procedural Service	Override 'Bundling' edits when billed according to AMA CPT coding guidelines.

Modifier	Description	Processing logic
62	Two Surgeons	Some procedures may pend for Medical Review and medical records may be required. Please refer to the "Claim Editing Overview" for procedure code pend criteria. 62.5% of allowance
66	Surgical Team	Pend for Medical Review. Medical records may be required.
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional	Override 'Frequency' edits when billed according to AMA CPT coding guidelines.
77	Repeat Procedure or Service by Another Physician or Other Qualified Health Care Professional	Override 'Frequency' edits when billed according to AMA CPT coding guidelines.
78	Unplanned Return to the Operating/ Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period	Override 'Bundling' edits when billed according to AMA CPT coding guidelines. Intra-Operative Percentage Indicator value as defined by the CMS Physician Fee Sched ule multiplied by the Blue Shield Provider Allowance
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	Override 'Bundling' edits when billed according to AMA CPT coding guidelines.
80	Assistant Surgeon	16% of allowance
81	Minimum Assistant Surgeon	16% of allowance
82	Assistant Surgeon (when qualified resident surgeon not available)	16% of allowance
91	Repeat Clinical Diagnostic Laboratory Test	Override 'Frequency' edits for repeat clinical diagnostic laboratory test when medically reasonable and billed according to AMA CPT coding guidelines. ***Refer to Frequency payment policy***.
AD	Medical Supervision	50% of allowance
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	14% of allowance
CT	CT performed with equipment not meeting NEMA standards	85% of allowance
FX	X-ray service performed using film	80% allowance of the technical component
FY	X-ray service performed using Computed Radiography	93% allowance of the technical component
P3	A patient with severe systemic disease	Add 1 unit
P4	A patient with severe systemic disease that is a constant threat to life	Add 2 units
P5	A moribund patient who is not expected to survive without the operation	Add 3 units

QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals	50% of allowance
QS	Monitored anesthesia care (MAC) service	100% of allowance
QW	CLIA (Clinical Laboratory Improvement Amendment) waived test	Modifier QW is used to indicate that the diagnostic lab service is a CLIA waived test and that the
QX	Qualified non-physician anesthetist with medical direction by a physician	50% of allowance
QY	Medical direction of one qualified non-physician anesthetist by an anesthesiologist	50% of allowance
QZ	CRNA Service: Without Medical Direction by a Physician	100% of allowance
RT, LT, E1-E4, FA, TA, F1-F9, T1-T9, LC, LD, RC, LM, RI	Anatomical Site Modifiers	Anatomical site modifiers may override edits.
TC	Technical Component	Reduced allowance for performing technical component of a global service.
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter	Override 'Bundling' edits when billed according to AMA CPT coding guidelines.
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner	Override 'Bundling' edits when billed according to AMA CPT coding guidelines.
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure	Override 'Bundling' edits when billed according to AMA CPT coding guidelines.
XU	Unusual non-overlap ping service, the use of a service that is distinct because it does not overlap usual components of the main service	Override 'Bundling' edits when billed according to AMA CPT coding guidelines.

Rationale

As per CMS and AMA coding standards, modifiers provide the extra information about the procedure and clinical scenario, and

- May affect reimbursement
- May be informational only

Reimbursement Guideline

Blue Shield of California will reference national or regional industry standards, such as Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and MUE (Medically Unlikely Edits) rules, and American Medical Association's (AMA) CPT guidelines, as coding standards and as guidance for payment policy. In claims payment scenarios where CMS and/or CPT reference is lacking or insufficient, the Payment Policy Committee (PPC) may develop customized payment policies that are based on other accepted or analogous industry payment standards and or expert input.

Resources

- **American Medical Association**
  https://www.ama-assn.org/
- **Centers for Medicare & Medicaid Services**
  https://www.cms.gov/
- **CMS Medicare Physician Fee Schedule (MPFS) Relative Value File**
  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Payment Policy.

Effective Date	Action	Reason
01/01/2002	New Policy Adoption	Payment Policy Committee
07/08/2017	Policy Revision	Payment Policy Committee
01/12/2018	Policy Revision	Payment Policy Committee
08/03/2018	Maintenance	Payment Policy Maintenance
03/07/2019	Policy Revision: Modifier Reimbursement Rate updated effective date of service 03/07/2019 for modifiers- 66, 76, 78, 80, 81, 82, AS, FX and FY.	Payment Policy Committee
09/01/2020	Added modifier 32	Payment Policy Committee
01/01/2022	Added modifier QS	Annual Maintenance

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.