# Payment Policy: Modifier to Procedure Code Validation

Reference Number: CC.PP.028
Product Types: ALL
Effective Date: 01/01/2013
Last Review Date: 12/01/2022

Coding Implications
Revision Log

**See Important Reminder at the end of this policy for important regulatory and legal information.**

**Policy Overview**
Modifiers are appended to procedure codes to indicate that the service has been altered by some circumstance, but the definition of the procedure or the procedure code itself is unchanged.

When a provider bills a modifier that is invalid for the procedure code billed, the claim line containing the invalid modifier to procedure code combination is denied by code editing software. This policy is relevant to modifiers identified as affecting payment.

The Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and public-domain specialty societies determine payment modifiers that are appropriate for billing with certain procedure codes. The AMA publishes Current Procedural Terminology (CPT) HCPCS Level I modifiers and CMS publishes the list of HCPCS Level II modifiers.

**According to the AMA (2022):**
*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 has not changed in its definition or code. Modifiers also enable healthcare professionals to effectively respond to payment policy requirements established by other entities (p. 709).*

**Application**
This policy applies to Professional and Outpatient institutional claims.

**Claims Reimbursement Edit**
The health plan's code editing software evaluates individual claim lines for invalid payment modifier to procedure code combinations. Procedure codes are denied when billed with a payment modifier that is inappropriate for the service billed or not clinically likely for the procedure code billed.

The software reviews modifier to procedure code combinations on the current claim only and does not review historical claims.

**Rationale for Edit**
Payment modifiers are to be assigned only for appropriate procedures.

**Coding and Modifier Information**
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are

**Definitions**

1. ***HealthCare Common Procedure Coding System*** (HCPCS), Level I Modifiers: Also known as CPT modifiers consisting of two numeric digits. These modifiers are in the range of 22-99. The list is updated annually by the AMA.
2. ***HealthCare Common Procedure Coding System*** (HCPCS), Level II Modifiers: Also known as the HCPCS modifiers and consist of two alpha-numeric characters. These modifiers are in the range of AA-VP. The list is updated annually by the CMS.
3. ***Modifier***: Two digit numeric or alpha-numeric descriptor that is used by providers to indicate that a service or procedure has been altered by a specific circumstance, but the procedure code and definition is unchanged.
4. ***Modifiers Affecting Payment***: Modifiers which impact how a claim or claim line will be reimbursed.

**Related Policies**

- CC.PP.013 Clinical Validation of Modifier -25
- CC.PP.014 Clinical Validation of Modifier -59
- CC.PP.020 Distinct Procedural Modifiers

**References**

1. *Current Procedural Terminology (CPT®)*, 2022
2. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS
3. *HCPCS Level II*, 2022
4. *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM), 2022
5. *ICD-10-CM Official Draft Code Set*, 2022
6. *Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.*

| Revision History | |
|---|---|
| 09/09/2016 | Corrected Modifier definitions for QW and QX |
| 02/24/2018 | Converted to updated template, conducted review, removed Modifier -21; Added Modifiers: -23,-32,-47,-63,-77,-90,-92,-95,-96,-97,-99,-QS,-XO,-XP,-XS,-XU |
| 04/01/2019 | Conducted review, verified codes , updated policy |
| 11/01/2019 | Annual Review completed |
| 11/01/2020 | Annual Review completed |

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| 11/30/2021 | Annual review completed; links updated |
| 12/01/2022 | Annual review completed; modifier table removed as this information is available in the listed references |

**Important Reminder**

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.



**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence.

Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.