Valid Modifier to Procedure Code Combinations

Last Updated: 3/12/2025 **Last Reviewed: 3/12/2025** **Originally Effective: 12/18/2006**

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

If yes, Texas Last Update Effective Date: n/a **Policy #: RPM019**

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All) **Provider Contract Status:** Any

Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** All

Reimbursement Guidelines

A. General

Clinical editing is utilized to identify appropriate and inappropriate modifier and procedure code combinations, as well as when a required modifier is missing from a line item.

B. Valid and Invalid Modifier/Procedure Combinations

1. Our clinical editing system identifies a specific list of modifiers that are appropriate to be billed with each five-digit procedure code. While both the individual procedure and modifier codes may be valid for the date of service, if the procedure and modifier combination is not appropriate to be used together, the line item will deny as an invalid modifier combination. These edits are currently applied to claims billed on CMS1500 and UB04/CMS1450 claim forms.

2. Valid modifier tables are configured based upon multiple sources, including but not limited to:
   a. CMS guidelines, where available, including the Medicare Physician Fee Schedule Database (MPFSDB) modifier indicators.
   b. CPT coding guidelines. Where instructions are explicit, CPT notes and guidelines regarding the use of modifiers with a particular code are incorporated.
   c. Code definitions and modifier definitions.
   d. Clinically derived and/or general claim convention experience.
   e. Medical specialty society information.
   f. In rare cases discrepancies exist between guidelines from two or more sources listed above. In these situations, we have sole discretion to determine which guideline to use to determine whether a modifier is appropriate to use with a specific procedure code.

3. Unlisted codes.
   a. An unlisted code does not describe a specific service or supply and is defined uniquely for each claim submitted, so most modifiers are not considered valid for submission with unlisted codes.
   b. Valid modifiers for unlisted codes:
      i. For unlisted anesthesia codes, modifiers AA, AD, GC, QK, QX, QY, QZ are appropriate to define whether the anesthesia service was shared or not.
      ii. Unlisted surgical codes:
         1) Assistant at surgery modifiers 80, 81, 82, and AS.
         2) Co-surgery (modifier 62).
         3) Team surgery (modifier 66).
         4) Stagged or related procedure (modifier 58).
         5) Unplanned related procedure (modifier 78).
         6) Unrelated procedure (modifier 79).
         7) Surgical care only (modifier 54).
         8) Postoperative management only (modifier 55).

9) Preoperative management only (modifier 56).

iii. For unlisted DME, orthotics, and prosthetics codes modifiers NU, RR, MS, and UE are required.

iv. Modifiers LT and RT are appropriate as informational modifiers. However, per CMS guidelines, modifiers LT and RT may not be reported on the same line item even if 2 units are billed. For more information, see details in the table here. [9]

c. All other modifiers are considered invalid for unlisted codes and may be denied as invalid procedure/modifier combinations. This includes, but is not limited to:

i. Bundling bypass modifiers:

1) Distinct procedural service (modifier 59).
2) Separate encounter (modifier XE).
3) Separate structure (modifier XS).
4) Separate practitioner (modifier XP).
5) Unusual non-overlapping service (modifier XU).
6) Significant separate E/M (modifier 25).
7) Unrelated E/M during postoperative period (modifier 24).

ii. Increased procedural services (modifier 22). [B]

iii. Reduced procedural services (modifier 52). [E]

4. To remedy an invalid modifier combination denial:
   a. If a line item is denied for an invalid modifier combination, the claim cannot be adjusted based upon a phone call or email to Customer Service or Provider Relations; a corrected claim will be needed. Records may need to accompany the corrected claim in some situations.
   b. If you believe the invalid modifier denial is incorrect, please submit a written provider appeal and include coding guidelines supporting why the procedure code and modifier combination should be considered valid.

5. Specific combination examples:
   a. Example # 1:
   58720 = *Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)*
   This code is already priced as bilateral. Modifier 50 is not a valid modifier with this code. 58720-50 would deny for invalid modifier combination.
   b. Example # 2:
   27506 = *Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws*
   Modifiers LT or RT would be valid for 27506 because there is a Right femur and a Left femur.
   c. Example # 3:
   20552 = *Injection(s); single or multiple trigger point(s), one or two muscle(s)*
   Modifiers LT or RT are not valid for 20552 because trigger points and muscles exist throughout the body, not in only two paired locations.

C. Required Modifier/Procedure Combinations

Our clinical editing system is also able to identify when a modifier or one of a selection of modifiers is required to be billed with a specific procedure code. If a required modifier is missing, a clinical edit denial will occur.

Please note the requirements for modifiers RR, NU, UE in the modifier-specific guidelines table.

D. Modifier-specific Guidelines

It is impossible to cover every possible modifier and/or combination in this document. However, the following information is offered to help address the most common questions and concerns submitted to Moda Health regarding invalid modifier combination denials or missing required modifier denials.

Modifier(s)	Moda Health Configuration & Reimbursement Guidelines	Examples of combinations which will deny
24, 25	Modifiers 24 and 25 are valid on Evaluation and Management (E/M) procedure codes only.	Do not use modifiers 24 and 25 with surgical codes, medicine procedures, diagnostic tests and procedures, etc.
26	Modifier 26 is considered valid for procedures with a Professional Component (PC)/Technical Component (TC) Indicator of 1 or 6.	Do not use modifier 26 for procedures with a Professional Component (PC)/Technical Component (TC) Indicator of 0, 2, 3, 4, 5, 7, or 9.
TC	Modifier TC is considered valid for procedures with a Professional Component (PC)/Technical Component (TC) Indicator of 1.	Do not use modifier TC for procedures with a Professional Component (PC)/Technical Component (TC) Indicator of 0, 2, 3, 4, 5, 7, 8, or 9.
50	Modifier 50 is considered valid on codes that have a bilateral indicator of 1 and 3. Report as a single line item with units = "1."	Do not use modifier 50 with procedure codes that have a bilateral indicator of 0, 2, or 9 on the Physician Fee Schedule; another modifier should be used or the code is already priced as bilateral.
51	Modifier 51 is considered valid for procedures with a multiple procedure indicator of 2, 3, 4, 5, 6, or 7.	The CMS Physician Fee Schedule indicates that modifier 51 is not eligible to be used with the CMT codes (98940 - 98943). Moda Health will deny 98940 - 98943 for invalid modifier combination when billed with modifier 51.
52	Modifier 52 (reduced services) signifies that only part of the code description was performed, some parts were omitted.	Do not use modifier 52 with: • Evaluation and management codes. • When another code is available to describe a lesser service. • With an all-or-nothing procedure code. • With an unlisted code. (More details at Modifier 52 Policy # RPM003.)
58	Modifier 58 is considered valid for procedures with a Global Days indicator setting of 000, 010, 090, or ZZZ. Modifier 58 is not considered valid for procedures with a Global Days indicator setting of XXX.	99213-58 will be denied for invalid modifier combination. May not be used with E/M codes. Modifier 58 may not be appended to radiology codes, infusion administration codes, or other non-surgical codes.
78	Modifier 78 is considered valid for procedures with a Global Days indicator setting of 000, 010, 090, or ZZZ. Modifier 78 is not considered valid for procedures with a Global Days indicator setting of XXX.	99213-78 will be denied for invalid modifier combination. May not be used with E/M codes. Modifier 78 may not be appended to radiology codes, infusion administration codes, or other non-surgical codes.

Modifier(s)	Moda Health Configuration & Reimbursement Guidelines	Examples of combinations which will deny
79	Modifier 79 is considered valid for procedures with a Global Days indicator setting of 000, 010, 090, or ZZZ. Modifier 79 is not considered valid for procedures with a Global Days indicator setting of XXX.	99213-79 will be denied for invalid modifier combination. May not be used with E/M codes. Modifier 79 may not be appended to radiology codes, infusion administration codes, or other non-surgical codes.
90	Modifier 90 = Reference (outside) laboratory Valid for laboratory test procedures. By definition, modifier 90 indicates the services described by the procedure code billed with modifier 90 attached were **NOT** performed by the physician or office submitting the claim.	36415-90 will be denied for invalid modifier combination. A drawing fee or venipuncture cannot be referenced out to another lab so modifier 90 should not be reported with CPT code 36415. If the office performs venipuncture (36415) to send the specimen to an outside laboratory for tests, then they have performed the venipuncture, and it is not correct to attach modifier 90 to 36415.
LT, RT	Modifiers LT and RT are only considered valid for procedure codes specific to body parts that exist only twice in the body, once on the left and once on the right (paired body parts). For example, eye procedures (e.g., cataract surgery) and knee procedures (e.g., total knee replacement). [1, 10] Modifiers LT and RT should be used when a procedure was performed on only one side of the body, to identify which one of the paired organs was operated upon. [10] Modifiers LT and RT may not be reported together on the same line. • If the service was performed on both sides of the body, modifier 50 is usually appropriate for use. [10, c] • If modifier 50 is not appropriate for some reason, report the code with modifier LT on one line item and the code with modifier RT on a separate line item, per CMS guidelines. [9]	LT and RT are not considered valid for toe procedures, excision of lesions, tendon/ligament injections (20550), or needle placements, etc. (Use finger and toe modifiers for finger and toe procedure codes; use eyelid modifiers for eyelid procedures.) If the code description is for a structure that occurs multiple times on one side of the body (e.g., fingers, tendons, nerves, etc.) and is not specific enough for you to be able to mark on a body diagram where the left or right procedure is performed without looking at the medical record (e.g., place an "x" on the left shoulder for 73030-LT), then LT and RT are not valid modifiers. (Modifier -59 may be needed to indicate a separate lesion, separate nerve, separate tendon, etc. for non-paired procedure codes.) If modifier LT and RT are both reported on the same line item, the modifier combination will deny. (e.g., 31296-LT-RT, A5505-LT-RT x 2 units)

Modifier(s)	Moda Health Configuration & Reimbursement Guidelines	Examples of combinations which will deny
NU, RR, UE	According to the CMS DMEPOS and DMAP fee schedules, specific codes must be billed with modifier NU, others must be billed with modifier RR, and still others must be billed with either NU, RR, or UE. There are also procedure codes that do not require one of these modifiers. If a modifier is required on the contracted fee schedule, Moda Health's Provider Pricing Configuration requires the presence of the correct modifier to correctly price the line item. **Effective 1/1/2021**, If the needed modifier from the contracted fee schedule is missing, the line item will be denied, and a corrected claim will be needed.	A4233 requires modifier NU. If modifier NU is not billed, A4233 will deny for a required modifier is missing. E0296 requires modifier RR. If modifier RR is not billed, E0296 will deny for a required modifier is missing. A4618 requires either modifier NU, RR, or UE. If one of these three modifiers is not used, A4618 will deny for a required modifier is missing.
QW	Modifier QW is considered valid for procedure codes on the CMS list of CLIA waived lab tests	Do not use modifier QW for lab test procedure codes not on the CMS list of CLIA waived procedure codes
SG	Modifier SG = ASC facility service Modifier SG is only valid for surgical codes	**Commercial claims –** Do not use modifier SG with related HCPCS codes for DME, surgical implants, equipment used during the surgery, supplies, drugs, etc. These items are related to the surgery, and in some cases are eligible for separate reimbursement, but they are not facility fees. **Medicare Advantage claims –** Effective 1/1/2008 modifier SG is no longer applicable for Medicare claims (CMS[8]). The valid modifier configuration for Medicare Advantage claims essentially ignores the presence or absence of modifier SG, and Medicare Advantage claims for non-surgical/ancillary procedure codes submitted with modifier SG will *not* deny. **Medicaid claims –** Medicaid rules vary from state to state. Please only use modifier SG with non-surgical/ancillary procedure codes when there is a specific instruction from your state's Medicaid authority to use modifier SG.

Definitions

Acronyms/Abbreviations

Acronym	Definition
AMA	American Medical Association
CCI	Correct Coding Initiative (see "NCCI")
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	Health Insurance Portability and Accountability Act
MUE	Medically Unlikely Edits
NCCI	National Correct Coding Initiative (aka "CCI")
PTP	Procedure-To-Procedure (a type of CCI edit)
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)

Modifier Definitions

Modifier	Modifier Description & Definition
Modifier 24	Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period.
Modifier 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
Modifier 26	**Professional Component:** Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier 26 to the usual procedure number.
Modifier TC	**Technical Component:** Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians. However, portable x-ray suppliers only bill for technical component and should utilize modifier TC. The charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.
Modifier LT	Left side (used to identify procedures performed on the left side of the body)
Modifier RT	Right side (used to identify procedures performed on the right side of the body)
Modifier NU	New equipment
Modifier RR	Rental (use the RR modifier when DME is to be rented)
Modifier QW	CLIA waived test
Modifier UE	Used durable medical equipment

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Modifier 22 – Increased Procedural Services," Moda Health Reimbursement Policy Manual, RPM007.
C. "Modifier 50 – Bilateral Procedure," Moda Health Reimbursement Policy Manual, RPM057.
D. "Modifier 51 - Multiple Procedure Fee Reductions," Moda Health Reimbursement Policy Manual, RPM022.
E. "Modifier 52 – Reduced Services," Moda Health Reimbursement Policy Manual, RPM003.
F. "Modifiers 58, 78, and 79 – Staged, Related, and Unrelated Procedures," Moda Health Reimbursement Policy Manual, RPM010.

G. "Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service." Moda Health Reimbursement Policy Manual, RPM027.
H. "Routine Venipuncture," Moda Health Reimbursement Policy Manual, RPM012.
I. "Technical Component (TC), Professional Component (PC/26), and Global Service Billing," Moda Health Reimbursement Policy Manual, RPM008.

Resources

1. CMS. "Clarification of Modifier Usage in Reporting Outpatient Hospital Services." Transmittal No. A-00-73. October 5, 2000. Accessed November 29, 2011. http://www.cap.org/apps/docs/medicare/program_memorandums/a0073.pdf , http://www.cms.gov/Transmittals/CMSPM/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS052339&intNumPerPage=2000
2. Jeannine Bouchard & Joanne Lespasio. "Hospital Outpatient Modifiers." *NHIC, Corp. Medicare Services.* Publication date February 2010. Accessed November 29, 2011. http://www.medicarenhic.com/PA/billing/02-2010%20Hospital%20Outpatient%20Modifiers.pdf .
3. Ingenix Inc. Staff. "Brush Up on CPT/HCPCS Modifiers." *ADVANCE for Health Information Professionals*. Publication date February 27, 2007. Accessed November 29, 2011. http://health-information.advanceweb.com/Article/Brush-Up-on-CPTHCPCS-Modifiers.aspx.
4. Robert S. Gold, MD, Glenn Krauss, RHIA. "To modify or not to modify? Coding for procedures on paired organs." *DCBA Interactive.* Accessed November 29, 2011. http://www.cditalk.com/content/148-To-modify-or-not-to-modify-Coding-for-procedures-on-paired-organs .
5. "Reader Questions: Use Modifier -50 or -RT/-LT, Not Both." *SuperCoder.com - The Coding Institute*. Accessed November 29, 2011. http://www.supercoder.com/articles/articles-alerts/nca/reader-questions-use-modifier-50-or-rt-lt-not-both/
6. "Most used modifier in ASC – Tips for Modifiers use in an Ambulatory Surgery Center." *medicalbillingcptmodifiers.com*. Published May 30, 2010. Accessed November 29, 2011. http://www.medicalbillingcptmodifiers.com/2010/05/most-used-modifer-in-asc.html
7. Grider, Deborah J. *Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage*. Chicago: AMA Press, 2004.
8. CMS. "Annual Type of Service (TOS) Update." Transmittal No. 1410. January 11, 2008. Last accessed January 3, 2020. Page 5 of 50. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1410CP.pdf .
9. CMS. "Medically Unlikely Edits (MUEs)." Medicare Claims Processing Manual (Pub. 100-4). Chapter 23 – Fee Schedule Administration and Coding Requirements, § 20.9.3.2.
10. CMS. "Modifiers -LT and -RT." *Medicare Claims Processing Manual* (Pub. 100-4), Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), § 20.6.3. Last updated January 25, 2024; Last accessed March 7, 2024.

Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
3/12/2025	Related Policies updated. Formatting updates. No policy changes.
3/13/2024	Clarified appropriate & inappropriate modifiers for unlisted codes. Related Policies, Resources, & footnotes updated. Minor rewording. No policy changes.

Date	Summary of Update
4/12/2023	Clarified modifiers LT and RT can't be combined on the same line item. Coding Guidelines & Sources and Resources updated. Formatting updates. No policy changes.
10/12/2022	Idaho added to Scope. Formatting updates. Policy History entries prior to 2022 omitted (in archive storage). No policy changes.
2/26/2013	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
12/18/2006	Original Effective Date (with or without formal documentation). Policy based on clinical editing software which uses AMA & CMS coding guidelines.