Payment Policy: Modifier Date of Service Validation

Reference Number: LA.PP.034
Product Types: ALL
Effective Date: 08/2020
Last Review Date: 08/20~~20~~22

Coding Implications
Revision Log

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

Policy Overview
Providers append modifiers to procedures and services to indicate that a procedure or 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 date a procedure or service was performed, the claim line containing the invalid modifier will be denied.

The Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) determine the Healthcare Common Procedure Coding System (HCPCS) modifiers which are valid for provider use. The AMA publishes the Current Procedural Terminology (CPT) HCPCS Level I modifiers and CMS publishes the valid list of HCPCS Level II modifiers.

> According to the AMA (20~~19~~21):
> *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.

Reimbursement
The health plan's code editing software evaluates individual claim lines for invalid or expired modifiers.

The software validates the modifier against reference logic containing the valid Level I and Level II HCPCS modifiers. If a claim line billed with a modifier is found to be invalid or expired for the date of service billed, then the claim line is denied.

This rule reviews modifier validity on the current claim only and does not review historical claims.

Rationale for Edit
Providers should bill the correct modifier for the date that services were rendered.

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 copyrighted 20~~19~~21, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Modifier	Descriptor
22-99	AMA modifiers See Appendix A of the CPT code manual
25,27,73 and 74	Modifiers for Ambulatory Surgery Center (ASC) Hospital Outpatient Use
A1-ZC	Level II Modifiers
P1-P6	Anesthesia Physical Status Modifiers

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 code 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.

References

1. *Current Procedural Terminology (CPT®)*, 20~~19~~21
2. *HCPCS Level II*, 20~~19~~21
3. *International Classification of Diseases*, ~~Tenth Revision, Clinical Modification~~ (ICD-10-CM), 20~~19~~21
4. *ICD-10-CM Official Draft Code Set*, 20~~19~~21
5. ~~*https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html*~~*https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS*
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Revision History	
08/15/2020	Converted corporate to local policy.
08/30/2022	Annual Review; Update: dates and links in the reference section from 2019 to 2021 Removed clinical and added payment policy in "Important Reminder" section"

Important Reminder

This ~~clinical policy~~payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this ~~clinical policy~~payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this ~~clinical policy~~payment policy. This ~~clinical policy~~payment policy is consistent with standards of medical practice current at the time that this ~~clinical policy~~payment policy was approved.

The purpose of this ~~clinical policy~~payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions 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 LHCC administrative policies and procedures.

This ~~clinical policy~~payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this ~~clinical policy~~payment policy. This ~~clinical policy~~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 ~~clinical policy~~payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this ~~clinical policy~~payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This ~~clinical policy~~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 ~~clinical policy~~payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Senior Director of Network Accounts: _____Electronic Signature on File_