Payment Policy: Modifier Date of Service Validation

Reference Number: CC.PP.034
Product Types: ALL
Effective Date: 01/01/2013
Last Review Date:04/01/2019

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 Procedural 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 (2016):**
> *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 will evaluate individual claim lines for invalid or expired modifiers.

The software will validate 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 will be 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 2018, 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-number 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®)*, 2018
2. *HCPCS Level II*, 2018
3. *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM), 2017
4. *ICD-10-CM Official Draft Code Set*, 2018
5. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html

Revision History	
02/24/2018	Converted to new template and conducted review; revised the list to include A1-A9; and ZA-ZC
04/01/2019	Conducted review, verified codes, updated policy.

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.

 Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.