curative

TITLE:	PROCEDURE TO MODIFIER GUIDELINES
DEPARTMENT:	PAYMENT POLICY
ORIGINAL EFF. DATE:	02/03/2026
REVISION DATE:	N/A

1. PURPOSE

This Payment Policy outlines clear and consistent reimbursement guidelines to ensure compliant, transparent, and timely payment for medically necessary, cost-effective care.

2. SCOPE

This policy applies to the reimbursement of covered services for all members and providers, consistent with plan benefits, contractual agreements, and regulatory requirements.

3. DEFINITIONS

The following terms are defined as follows regarding this P&P.

3.1. **Current Procedural Terminology** (CPT®) A medical code set maintained by the American Medical Association (AMA) that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT is included in Level I Healthcare Common Procedure Coding System (HCPCS).

3.2. **HCPCS Level II** A standardized coding system that is used primarily to identify medical supplies, durable medical equipment, non-physician services, and services not represented in the Level I code set CPT.

3.3. **Modifier** A two-digit code added to a CPT code to signal special circumstances affecting the service without altering the code's basic meaning

3.4. **Definitive Source** Definitive Sources contain the exact codes, modifiers, or very specific instructions from the given source.

3.5. **Interpretive Source** An edit source that includes guidelines; however, no exact or specific code or modifier information is listed. Therefore, an interpretation must be made as to what codes correlate to the guidelines. Additionally, an interpretation may be applied to surrounding or similar codes based on related definitively sourced edits.

4. POLICY

These payment policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a Curative member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization

and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our payment policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current payment policies are not followed, Curative may:

1. Reject or deny the claim.
2. Recover and/or recoup claim payment.

Refer to the Provider Manual for claim reconsideration, appeals, and dispute resolution processes.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

The services must also be within the scope of practice for the relevant type of provider in the State in which they are furnished and within the provider's credentials/training.

Reimbursement Guidelines

In accordance with correct coding, Curative Health will consider reimbursement for a procedure code/modifier combination only when the modifier has been used appropriately. Note that any procedure code reported with an appropriate modifier may also be subject to other Curative Health payment policies.

- Use modifiers only when they accurately describe the service performed.
- Follow AMA, CPT®, and CMS guidelines for correct modifier usage.
- Do not use multiple modifiers together if one specific modifier exists for the service.
- Incorrect or missing modifiers can lead to denials or payment adjustments.

Common Situations Where Modifiers are used:

- Professional vs. technical components of a service.
- Bilateral or multiple procedures.
- Separate/distinct services performed on the same day.
- Staged, repeat, or reduced services.
- Telemedicine or site-specific procedures.

Avoiding Common Denials:

- **Do not bill** 95 and GT on the same claim line.

- Deceased Modifier Services - Supplies and/or devices are not reimbursable if modifier CA, PM, P6 or QL have been reported on a prior date of service.

Common modifiers, descriptions, and details are outlined below. This is not a comprehensive list of all modifiers defined within the CPT and HCPCS code sets. Therefore, the absence of a modifier from this list does not indicate that it is not recognized by Curative Health.

Modifiers Defined by CPT® Appendix A

Modifier	Description	Details
22	Increased Procedural Services	Indicates that a service or procedure requires increased intensity or effort.
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period	Designates that an unrelated E&M was performed beginning the day after and within the postoperative period of an unrelated 10-day or 90-day global procedure.
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	Designates that a separately identifiable E&M service was performed on the same day as another procedure. Modifier 25 is only applicable on professional claims.
26	Professional Component	When the physician's component is separately reportable, the service may be identified by appending modifier -26 to the procedure code. Note Curative Health denies "Incident To" codes identified with a CMS PC/TC indicator 5 in the NPFS when reported in a facility place of service when billed by a physician. Modifiers -26 and TC cannot be used with these codes. Curative Health does not reimburse codes identified by CMS as having no professional component (PC/TC Indicator of 3,4, or 9) when billed with a -26 modifier.
47	Anesthesia by Surgeon	No additional benefits are allowed above the total allowed for the surgical procedure if the anesthesia services are not administered by, or under the supervision of, a doctor other than the attending surgeon or assistant surgeon.
50	Bilateral Procedure	Use of the 50 modifier will not result in additional reimbursement when used with procedures which cannot be performed bilaterally or for which the base CPT code signifies a bilateral procedure.
51	Multiple Procedures	Designates multiple procedures that are performed at the same session by the same provider, other than evaluation and management services, physical medicine and rehabilitation services, or provision of supplies. Note: This modifier is not appropriate to append to evaluation and management services. This modifier is not to be appended to designated "add-on" codes.
52	Reduced Services	Indicates that a service or procedure has been partially reduced or eliminated at the physician's discretion.

53	Discontinued Procedure	Indicates a procedure was started but discontinued. Modifier 53 is not appropriate for use with: ● Facility billing ● Evaluation and management (E/M) services ● Elective cancellation of a service prior to anesthesia induction and/or surgical preparation in the operating suite. ● Laboratory panel code
54	Surgical Care Only	Indicates when a physician or other qualified healthcare professional furnishes only part of a global surgical package and relinquishes the other portion(s) of the surgical package to another physician or other qualified healthcare professional. Modifiers 54, 55, and 56 are appended to the surgical procedure code and only apply to services with a 10- or 90-day global period.
55	Postoperative Management Only	
56	Preoperative Management Only	
57	Decision for Surgery	Appended when an evaluation and management service that results in the initial decision to perform surgery. It is intended to report that the decision to perform major surgery occurred on the day of or day prior to, a major (90-day global) surgical procedure.
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	Designates a staged or related procedure performed during the postoperative period of the first procedure by the same physician. Modifier 58 is to be reported with the applicable code for the staged procedure. Modifier 58 is not applicable to unrelated procedures during the postoperative period, assistant surgeon claims, or when the initial procedure does not carry a global period.
59	Distinct Procedural Service	Indicates when a procedure is distinct or independent from another non-evaluation and management service performed on the same day. Note: The Centers for Medicare & Medicaid Services (CMS) has established four HCPCS modifiers to define subsets of modifier 59. These modifiers function in the same manner as modifier 59. Since the HCPCS modifiers are more detailed descriptions of modifier 59, it would be incorrect to include both on the same claim line according to CMS. Therefore, any code appended with 59 in addition to XE, XP, XS, or XU will not be eligible for reimbursement.
62	Two Surgeons	Indicates that services were performed by two surgeons
66	Surgical Team	Indicates that services were performed by a surgical team
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia	Appended to indicate that the procedure was discontinued prior to completion. This modifier is not applicable for professional provider billing
74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia	

76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional	Indicates that a procedure or service was repeated subsequent to the original procedure or service by the same provider on the same patient on the same date of service or within the post-operative period.
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional	Indicates the same procedure or service has been performed by a different provider to the same patient on the same date of service or within the post-operative period of the original procedure.
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	In order for a procedure code billed with modifier 78 or 79 to be eligible for reimbursement, Curative Health must have evidence that a procedure was billed on the same date of service or within the postoperative period as defined by the 0, 10, or 90 day postoperative period definition.
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	
80	Assistant Surgeon	Indicates that services were performed by an assistant surgeon
81	Minimum Assistant Surgeon	
82	Assistant Surgeon (when qualified resident surgeon not available)	
90	Reference (Outside) Laboratory	Represents a reference (outside) laboratory and will only be eligible for reimbursement if billed by a provider with a specialty designation of Laboratory or Pathology.
91	Repeat Clinical Diagnostic Laboratory Test	Used to report repeat laboratory tests on the same date of service to obtain multiple test results. Modifier 91 should not be used when tests are repeated to confirm initial test results due to testing problems with equipment or specimens or with codes that describe a series of test results, such as glucose tolerance or evocative suppression tests.
92	Alternative Laboratory Platform Testing	Used for alternative laboratory platform testing. Only HIV testing will be eligible for reimbursement when billed. All other codes containing this modifier will not be eligible for reimbursement.
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System	Used to designate when a service is a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified healthcare professional.
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System	Used to designate when a service is a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified healthcare professional.

Level II HCPCS/National Modifiers

Modifier	Description	Details
AA	Anesthesia services performed personally by anesthesiologist	Physicians must report appropriate anesthesia modifiers with general anesthesia services to denote whether the service was personally performed, medically directed, medically supervised, or represented by monitored anesthesia care. Also, services rendered by CRNAs must report the appropriate anesthesia modifier to indicate whether the service was performed with or without medical direction by a physician. Appropriate modifiers for anesthesia services are: AA, AD, GC, QK, QX, QY, and QZ. General anesthesia services (CPT 00100-01969) will be denied if billed without an appropriate modifier. Anesthesia modifiers should only be appended to anesthesia services. Additional service modifiers may be appropriate to use for anesthesia services, however when inappropriate service modifiers are appended to an anesthesia code, that service will not be eligible for reimbursement.
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	This modifier designates that services were provided by a physician assistant, nurse practitioner or nurse midwife for an assistant at surgery.
AT	Acute Treatment	Used in conjunction with chiropractic manipulative treatment CPT Codes 98940-98942 to designate acute treatment. Modifier AT designates active/corrective treatment to treat acute or chronic subluxation and is not to be used for maintenance therapy.
E1 - E4	Eyelid Modifiers: • E1 - Upper left, eyelid • E2 - Lower left, eyelid • E3 - Upper right, eyelid • E4 - Lower right, eyelid	Anatomic Modifier - Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims.
FA - F9	Finger Modifiers: • FA - Left hand, thumb • F1 - Left hand, second digit • F2 - Left hand, third digit • F3 - Left hand, fourth digit • F4 - Left hand, fifth digit • F5 - Right hand, thumb • F6 - Right hand, second digit • F7 - Right hand, third digit • F8 - Right hand, fourth digit • F9 - Right hand, fifth digit	Anatomic Modifier - Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims.
FS	Split (or shared) evaluation and management visit	Used to designate an E&M service that was performed in part by a physician and in part by other nonphysician practitioners in a facility setting.
GC	This service has been performed in part by a resident under the direction of a teaching physician	Appended to a service that has been completed by a resident in a teaching facility in part under direction and supervision of a teaching physician.
GG	Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day	Consistent with CMS policy, specific modifiers are required when both a screening and diagnostic mammogram are performed on the same date of service. In this scenario, the diagnostic mammogram must be appended with Modifier GG in order to be eligible for reimbursement. Similarly, the screening mammogram must also be appended with Modifier

		59, XE, XP, or XU otherwise, the screening mammogram will not be eligible for reimbursement.
GN	Services delivered under an outpatient speech language pathology plan of care	Curative will require certain codes that are designated by CMS as “always therapy” to be filed with the appropriate modifier (GP, GO, or GN). This allows correct payment when they are performed under the physical therapy, occupational therapy, or speech-language pathology plan of care.
GO	Services delivered under an outpatient occupational therapy plan of care	
GP	Services delivered under an outpatient physical therapy plan of care	
GQ	Via asynchronous telecommunications system	Used to designate when a service is an asynchronous interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified healthcare professional.
GT	Via interactive audio and video telecommunication systems	Used to designate when a service is a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified healthcare professional.
JW	Drug amount discarded/not administered to any patient	Used to designate when a portion of a single-dose vial or package was discarded. Should be reported with two lines: one with the drug code and modifier JW for the discarded amount and one with the same drug code without modifier JW for the administered amount. Modifier JW is not to be reported with a multi-dose vial or package or in conjunction with modifier JZ.
JZ	Zero drug amount discarded/not administered to any patient	Used to designate when the entirety of a single-dose vial or package was administered. Modifier JZ is not to be reported with a multi-dose vial or package or in conjunction with modifier JW.
LC	Left Circumflex Coronary Artery	Anatomic Modifier - Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims.
LD	Left Anterior Descending Coronary Artery	
LM	Left Main Coronary Artery	
LT	Left Side (used to identify procedures performed on the left side of the body)	Anatomic Modifier - Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims.
PA	Surgical or other invasive procedure on wrong body part	Indicates Never Events and are not considered reimbursable services.
PB	Surgical or other invasive procedure on wrong patient	

PC	Wrong surgery or other invasive procedure on patient	
PI	Positron emission tomography (PET) or PET/computed tomography (CT) to inform the initial treatment strategy of tumors that are biopsy proven or strongly suspected of being cancerous based on other diagnostic testing	Curative Health requires PET scans to be billed with a PI or a PS modifier to be considered reimbursable.
PS	Positron emission tomography (PET) or PET/computed tomography (CT) to inform the subsequent treatment strategy of cancerous tumors when the beneficiary's treating physician determines that the PET study is needed to inform subsequent antitumor strategy	
QW	CLIA Waived Test	Indicates a Clinical Laboratory Improvement Amendment (CLIA) waived test and the possession of a CLIA certificate that allows the performance and reporting of CLIA-waived tests.
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	Physicians must report appropriate anesthesia modifiers with general anesthesia services to denote whether the service was personally performed, medically directed, medically supervised, or represented by monitored anesthesia care. Also, services rendered by CRNAs must report the appropriate anesthesia modifier to indicate whether the service was performed with or without medical direction by a physician. Appropriate modifiers for anesthesia services are: AA, AD, GC, QK, QX, QY, and QZ. General anesthesia services (CPT 00100-01969)* will be denied if billed without an appropriate modifier. Anesthesia modifiers should only be appended to anesthesia services. Additional service modifiers may be appropriate to use for anesthesia services, however when inappropriate service modifiers are appended to an anesthesia code, that service will not be eligible for reimbursement.
QX	CRNA service: with medical direction by a physician	
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist	
QZ	CRNA service: without medical direction by a physicianInteractive	
RC	Right Coronary Artery	Anatomic Modifier - Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims.
RI	Ramus Intermedius Coronary Artery	
RR	Rental (use the RR modifier when DME is to be rented)	Capped rental DME must be appended with Modifier RR.
RT	Right Side (used to identify procedures performed on the right side of the body)	Anatomic Modifier - Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims.
SL	State supplied vaccine	Vaccines and toxoids provided at no cost by the state are not eligible for reimbursement.
SS	Home infusion services provided in the infusion suite of the IV therapy provider	Used with the codes for home infusion therapy including infusion, injection and other administrations to indicate the administration was provided in the ambulatory infusion suite of the home infusion therapy provider.

TA - T9	Toe Modifiers: • TA - Left foot, great toe • T1 - Left foot, second digit • T2 - Left foot, third digit • T3 - Left foot, fourth digit • T4 - Left foot, fifth digit • T5 - Right foot, great toe • T6 - Right foot, second digit • T7 - Right foot, third digit • T8 - Right foot, fourth digit • T9 - Right foot, fifth digit	Anatomic Modifier - Codes for site-specific procedures submitted without appropriate modifiers are assumed to be on the same side or site. Services provided on separate anatomic sites should be identified with the use of appropriate site-specific modifiers to allow automated, accurate payment of claims.
TC	Technical Component	Designates the technical component of a service. When the technical component is separately reportable, the service may be identified by appending modifier TC to the procedure code. **Note: Curative Health does not reimburse technical component services billed separately from the facility claim when performed in a facility place of service.
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter	Modifiers XE, XP, XS, and XU should be used instead of modifier 59 when the modifier appropriately describes the service. According to CMS, these modifiers are a more detailed description of modifier 59 and it would be incorrect to include both on the same claim line. Therefore, any code appended with 59 in addition to XE, XP, XS, or XU will not be eligible for reimbursement.
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner	
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure	
XU	Unusual nonoverlapping service, the use of a service that is distinct because it does not overlap usual components of the main service	

5. REFERENCE DOCUMENTS AND MATERIALS

5.1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

5.2. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

6. COLLABORATING DEPARTMENTS

6.1. Claims

6.2. Compliance

6.3. Medical Management

6.4. Network

6.5. System Configuration

7. POLICY & PROCEDURE CONTROL

This Policy will be reviewed at least annually and as necessary.

REVISION HISTORY			
Date	**Author**	**Version**	**Comments**
2025-11-03	CJW	001	Initial Version