Priority Health	BILLING POLICY No. 055

FACILITY MODIFIERS

Date of origin: Nov. 11, 2024	Review dates: 2/2025, 6/2025

APPLIES TO

- Commercial
- Medicare

DEFINITION

Modifiers indicate that a service or procedure performed has been altered by some specific circumstance, but not changed in its definition or code. They are used to add information or change the description of service to improve accuracy or specificity. Modifiers can be alphabetic, numeric or a combination of both, but will always be two digits.

POLICY SPECIFIC INFORMATION

Facility modifiers

- **53**: Discontinued Procedure
- **AS**: Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
- **CG**: Policy criteria applied
- **EA**: Erythropoietic stimulating agent (ESA) administered to treat anemia due to anticancer chemotherapy
- **EB**: Erythropoietic stimulating agent (ESA) administered to treat anemia due to anticancer radiotherapy
- **EC**: Erythropoietic stimulating agent (ESA) administered to treat anemia not due to anticancer radiotherapy or anticancer chemotherapy
- **ED**: Hematocrit level has exceeded 39% (or hemoglobin level has exceeded 13.0 G/dl) for three or more consecutive billing cycles immediately prior to and including the current cycle
- **EE**: Hematocrit level has not exceeded 39% (or hemoglobin level has not exceeded 13.0 G/dl) for three or more consecutive billing cycles immediately prior to and including the current cycle
- **GT**: Via interactive audio and video telecommunication systems
- **GX**: Notice of liability issued, voluntary under payer policy
- **JA**: Administered intravenously
- **JB**: Administered subcutaneously
- **V5**: Vascular catheter (alone or with any other vascular access)
- **V6**: Arteriovenous graft (or other vascular access not including a vascular catheter)
- **V7**: Arteriovenous fistula only (in use with two needles)

Place of service

Facility modifiers are billed on a UB-04 only.

Usage

53

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the wellbeing of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure.

Note: This modifier isn't used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that's partially reduced or cancelled as a result of extenuating circumstances or those that threaten the wellbeing of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

AS
Append this modifier to appropriate procedure codes when non-physician practitioners (NPPs) are assisting a principal surgeon as an assistant surgeon. The assistant at surgery provides more than ancillary services. NPPs include a CNS, NP and PA. This modifier may only be submitted with surgery codes, and additional documentation is required upon submission.

Documentation required in the medical record:

1. A statement that no qualified resident was available to perform the service, **or**
2. A statement indicating that exceptional medical circumstances exist, **or**
3. A statement indicating the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative or postoperative care of his/her patients.

CG
Rural health clinics (RHCs) shall report modifier CG on RHC claims and claim adjustments. You should report modifier CG on one line with a medical and/or a mental health HCPCS code that represents the primary reason for the medically necessary face-to-face visit. This line should have the bundled charges for all services subject to coinsurance and deductible. If only preventive services are furnished during the visit, report modifier CG with the preventive service HCPCS code that represents the primary reason for the medically necessary face-to-face visit.

EA
Use when the provider administers erythropoiesis-stimulating agents (ESAs) to a patient who takes chemical compounds or drugs for cancer.

GT
Used to indicate telehealth services. Except for demonstrations in Alaska and Hawaii, all telehealth must be interactive.

GX
Use the modifier GX to provide beneficiaries with voluntary notice of liability regarding services excluded from Medicare coverage by statute. Must be used with non-covered charges only.

Related denial language

- pf6 – ESRD modifier V5, V6, or V7 required with Rev Code 0821
- x82 – Units > 1 for bilateral procedure with modifier 50
- pg0 – Modifier GZ indicates this is not eligible for payment

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added "Disclaimer" section
June 19, 2025	Added "Related denial language" section