Priority Health	BILLING POLICY No. 055

FACILITY MODIFIERS

Date of origin: Nov. 11, 2024	Review dates: None yet recorded

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.

CHANGE / REVIEW HISTORY

Date	Revisions made