CENTENE Corporation

Payment Policy: Modifier to Procedure Code Validation

Reference Number: CC.PP.028
Product Types: ALL
Effective Date: 01/01/2013
Last Review Date: 10/14/2025

Coding Implications
Revision Log

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

Policy Overview

Medical Coding Modifiers are two characters appended to procedure codes to provide additional details about the medical procedure, service(s) or supply that was performed without changing or altering the American Medical Association (AMA) Current Procedural Terminology (CPT) definition of the procedure or the procedure code. The AMA publishes the list of HCPCS Level I (CPT) Modifiers, while CMS publishes the list of HCPCS Level II Modifiers.

In addition to maintaining accurate claim payment and reimbursement, using the appropriate modifiers is crucial for accurate coding and billing. The AMA, public-domain specialty societies, and the Centers for Medicare and Medicaid Services (CMS) decide whether payment modifiers are permissible for billing with specific procedure codes.

CPT Modifiers

The following are modifiers that are maintained and have a copyright with CPT. Modifier examples include:

- 25: Significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same date of the procedure or other service.
- 26: Professional Component of a procedure is being billed
- 59: Distinct Procedure Service

HCPCS Level II Modifiers

Maintained by CMS, these modifiers are two letters and alphanumeric. Examples include:

- FA: Left Hand, thumb
- TC: Technical Component of a procedure is being billed
- XE: Separate Encounter

Pricing and Informational Modifiers

Modifiers are categorized as either pricing or informational. Pricing modifiers directly impact the reimbursement amount for the reported CPT or HCPCS code. Informational modifiers provide additional context or details but do not affect payment. When multiple modifiers are reported, pricing modifiers should be listed before informational modifiers to ensure proper claims processing and reimbursement. Statistical modifiers, also known as informational modifiers, are used to override CMS's Procedure-to-Procedure (PTP) changes and offer details for the CPT or HCPCs code reported. They have no effect on claim price and enable payment for both codes in the coding pair.

When a modifier is submitted that is not valid for the associated procedure code, the claim line will be denied by code editing software as an Invalid Modifier-to-Procedure Code Combination. This policy applies specifically to payment modifiers, as they directly influence reimbursement.

As AMA stated, *"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."*

Application
This policy applies to Professional and Outpatient institutional claims.

Claims Reimbursement Edit
The health plan's code editing software evaluates individual claim lines for invalid payment modifier to procedure code combinations. Procedure codes are denied when billed with a payment modifier that is inappropriate for the service billed or not clinically likely for the procedure code billed.

The software reviews Modifier to Procedure code combinations on the current claim only and does not review historical claims.

Rationale for Edit
Payment modifiers are to be assigned only for appropriate procedures.

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 2026, 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.

Definitions
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.

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.

Modifier: Two digit numeric or alpha-numeric 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.

Modifiers Affecting Payment: Modifiers which impact how a claim or claim line will be reimbursed.

Related Policies

- CC.PP.013 Clinical Validation of Modifier -25
- CC.PP.014 Clinical Validation of Modifier -59
- CC.PP.020 Distinct Procedural Modifiers

References

1. Current Procedural Terminology (CPT®), 2026
2. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS
3. HCPCS Level II, 2026 https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update
4. https://www.cms.gov/medicare/coding-billing/ncci-medicare
5. https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system
6. https://www.ama-assn.org/system/files/reporting-CPT-modifier-25.pdf

Revision History	
09/09/2016	Corrected Modifier definitions for QW and QX
02/24/2018	Converted to updated template, conducted review, removed Modifier -21; Added Modifiers: -23, -32,-47, -63,-77,-90,-92,-95,-96,-97,-99,-QS,-XO,-XP,-XS,-XU
04/01/2019	Conducted review, verified codes, updated policy
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/30/2021	Annual Review completed; links updated
12/01/2022	Annual Review completed; modifier table removed as this information is available in the listed references
12/15/2023	Annual review completed; removed AMA page number 709 from document on “According to the AMA” as well as removed the year. Added reference number 6, AMA Reporting CPT Modifier 25 as page 2 has verbiage for modifiers according to the AMA.
3/5/2024	Updated Policy overview to describe the modifier classifications and usage. Added information to explain Pricing and Informational Modifiers. Changed Per AMA to "As AMA stated...". Updated HCPCs links; Added CMS NCCI link; Removed ICD 10 reference of ICD is not listed in the policy as well as the draft code set listed.
11/19/2024	Annual Review completed
10/14/2025	Annual Review completed; Validated policy content, references and links; Added revision date

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.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and 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.

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