If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSOK may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSOK has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Modifier Reference Policy

Policy Number: CPCP023

Version 2.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: March 17, 2023

Plan Effective Date: March 30, 2023

Description

This policy serves as a general reference for appending modifiers to the appropriate procedure codes. This policy is not intended to impact care decisions or medical practice. The American Medical Association (AMA) Current Procedural Terminology (CPT) manual and The Centers for Medicare & Medicaid Services (CMS) defines modifiers that may be appended to CPT/HCPCS codes to provide additional information about the services rendered. For

the purposes of this policy, a modifier should be appended to denote additional information about the service rendered. Modifiers consist of two numeric or alphanumeric characters. All valid CPT and HCPCS modifiers are accepted into the claims processing system used to review claims submitted. Some modifiers have claims logic that may impact claim reimbursement while others may be informational only.

Reimbursement Information:

Modifiers may be appended to CPT/ HCPCS code(s) if the service or procedure is clinically supported for use of modifiers. A claim should be submitted with the correct modifier-to-procedure code combination. Modifiers should not be appended to a CPT/HCPCS code(s) to circumvent a National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edit if the service or procedure is not clinically supported for the use of a modifier. Claim submissions may be denied if a claim contains an inappropriate modifier-to-procedure code combination. In this case, a corrected claim submission with the correct modifier-to-procedure code combination will be necessary to be considered for reimbursement. Medical records or other documentation should accompany the claim to ensure appropriateness of claim reimbursement. The plan reserves the right to request supporting documentation. Claims may be reviewed on a case-by-case basis.

If billing with more than one modifier, list the modifier that will impact reimbursement first.

The modifiers listed below may appear in some of the material on the applicable state plan's provider website. The following is not an all-inclusive list and modifiers may be added or removed with appropriate notice. The inclusion of a modifier below does not guarantee reimbursement.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER

22	Increased Procedural Services	Append modifier to indicate a service or procedure provided is significantly greater than that usually required.
		• Documentation should support substantial additional work and the reason for the additional work which may include:
		  ○ Time
		  ○ Severity of patient's condition
		  ○ Increased intensity
		  ○ Technical difficulty of procedure
		  ○ Physical and mental effort that was required
		• Modifier 22 should not be appended to an E/M service.
		• May be appended for field avoidance.
		• Should be submitted with supporting documentation.

23	Unusual anesthesia	Append modifier in the second modifier position when a pricing anesthesia modifier accompanies it in the first modifier position and the service rendered is monitored anesthesia care (MAC). • Modifier 23 may be reported on the procedure code of a basic service if a procedure required no anesthesia or local anesthesia but because of unusual circumstances must be done under general anesthesia.
24	Unrelated Evaluation and Management (E/M) service by the	Append modifier if an unrelated E/M service by the same physician or other qualified health care professional during a post-operative

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
	same physician or other qualified health care professional during a postoperative period	period occurs. • Modifier 24 is applied to two code sets, E/M services and general ophthalmological services for eye examinations.
25	Significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service	Append modifier to a significant, separately identifiable E/M service by the same physician or other health care professional on the same day of a procedure or other service. • A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.

26	Professional component	Append modifier only when the professional component is billed when certain services combine both the professional and technical services in one procedure code.
		• Requires a separate interpretation and report.
		• Modifier 26 denotes the professional component for the following types of service, such as:
		  • Lab
		  • Radiology
		  • Radiation Therapy

TC	Technical Component	Append modifier only when the technical component is billed when certain services combine both the professional and technical services in one procedure code.
		• Modifier TC denotes the technical component for the following types of service, such as:
		  • Lab
		  • Radiology
		  • Radiation Therapy

33	Preventive services	Append to codes represented for evidence-based services in accordance with a United States Preventive Services Task Force (USPSTF) A and B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory). • Modifier 33 should be used with CPT/HCPCS codes representing preventive care services. Note, for separately reported services specifically identified as preventive or inherently preventive per the code description, should not be submitted with modifier 33. • For additional information on Preventive Services, refer to CPCP006 Preventive Health Services.
47	Anesthesia by surgeon	Append modifier in the second modifier position when a pricing

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
		anesthesia modifier accompanies it in the first modifier position and the service rendered is monitored anesthesia care (MAC). • Anesthesiologist is not covered with this modifier. • Does not include local anesthesia, only applies to regional or general anesthesia when provided by the surgeon by adding 47 to the basic service. • Is not used for the anesthesia procedure.
50	Bilateral procedure	Modifier 50 is used to report bilateral procedures that are performed during the same service. The use of modifier 50 is applicable only to services and/or procedures performed on identical anatomic sites, aspects, or organs. (See Anatomical Modifier section for additional information related to modifier 50) • This modifier can be used for diagnostic, radiology, and surgical procedures. • Modifier 50 should not be used when the procedure code descriptor indicates bilateral and should not be used when RT and LT would be applicable to the services. • When using Modifier 50 to indicate a procedure was performed bilaterally, the modifiers LT (Left) and RT (Right) should not be billed on the same service line. Modifiers LT or RT should be used to identify which one of the paired organs were operated on, when applicable. Billing procedures as two lines of service using the left (LT) and right (RT) modifiers for a bilateral service is not the same as identifying the procedure with Modifier 50. • When billing for a bilateral service, a procedure code with the Bilateral Surgery Flag 1 Medicare Physician Fee Schedule (MPFS) indicating that the code is defined as a bilateral service, should be reported on one service line with one unit and Modifier 50 appended to the procedure code. • Should not be appended to designated add-on codes.
51	Multiple procedures	Append modifier to an additional procedure or service when there are multiple procedures or services (not including E/M services) on the same day, during the same surgical session by the same individual. • Should not be appended to modifier 51 exempt codes. • Should not be reported on all lines of service.
52	Reduced services	Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
		• See modifier 73 or 74 for facility. • Append modifier for unusual, reduced circumstances. • Should not be appended to report time-based codes. • Should not be used on E/M services.
53	Discontinued procedure	Under certain circumstances, the physician or other qualified healthcare professional may elect to terminate a surgical or diagnostic procedure due to circumstances that may threaten the well-being of the patient. • Append modifier for unusual, discontinued circumstances. • Should not be used on E/M services. • Should not be used to report a cancellation of a procedure.
54	Surgical care only	Append modifier when a physician or other qualified healthcare professional performs a surgical procedure, and another physician or other qualified healthcare professional performs the preoperative or postoperative management services. • Append modifier for the surgical care only.
55	Postoperative management only	Append modifier when a physician or other qualified healthcare professional performs a surgical procedure, and another physician or other qualified healthcare professional performs the postoperative management services. • Append modifier for postoperative management services only. • Post-operative care should be reported with the same date of service as the surgical care. The date of service is the date the surgical care was rendered.
56	Preoperative management only	Append modifier when a physician or other qualified healthcare professional performs a surgical procedure, and another physician or other qualified healthcare professional performs the preoperative management services. • Append modifier for preoperative management services only. • Should be reported with the date of service.
57	Decision for surgery	Append modifier to indicate an E/M service resulted in initial decision to perform surgery the day before a major surgical procedure or the day of the major surgical procedure. • Append only to an E/M code as described above. • A major surgery has a 90-day post-operative surgery period (90 day global) and a preoperative surgery period that includes the day before surgery or the day of surgery.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
58	Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period	Append modifier to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. • Append modifier when performing a second or related procedure during the postoperative period. • Should not be reported for unrelated procedures during the postoperative period.
59	Distinct procedural service	Under certain circumstances, it may be necessary to indicate a procedure or service was distinct or independent from other non-evaluation and management (E/M) services performed on the same day. • Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. • Refer to the current CPT guidelines for additional information. • In order to bill this modifier, documentation must support a different session, different procedure or surgery, different site or separate organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same individual. • Additional modifiers should be evaluated to determine the appropriate usage such as XE, XS, XP and XU.
62	Two surgeons	Append modifier if two surgeons with different specialties are required to perform a specific procedure on the same patient during an operative session, both acting as primary surgeons. If co-surgeon acts as an assistant in the performance of an additional procedure, other than those reported with modifier 62, during the same surgical session, those services must be reported using different procedure codes with modifier 80 or 82, as appropriate. • Both surgeons should append modifier 62 on the submitted claim. • The procedure code and diagnosis code should be the same on the submitted claim. • For additional information, refer to CPCP009 Co-Surgeon/Team Surgeon Modifiers.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
66	Surgical team	Append modifier when more than two surgeons of different specialties are working together under the "surgical team" concept. • Should be submitted with supporting documentation that includes each surgeon's description of their performance during the procedure. • Both surgeons should submit this modifier on only those services where they are acting as primary surgeons. • For additional information, refer to CPCP009 Co-Surgeon/Team Surgeon Modifiers.
73	Discontinued out-patient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia	Append modifier when reporting a discontinued outpatient/hospital ambulatory surgical center (ASC) procedure prior to the administration of anesthesia due to extenuating circumstances or a threat to the well-being of a member.
74	Discontinued out-patient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia	Append modifier when a reporting termination of a surgical or diagnostic outpatient/hospital ambulatory surgical center (ASC) procedure after the administration of anesthesia or after the procedure was started due to extenuating circumstances or a threat to the well-being of a member.
76	Repeat procedure or service by same physician or other qualified health care professional	Append modifier only when a procedure or service is repeated on the same date of service by the same physician or other qualified health care professional subsequent to the original procedure or service. • This modifier should not be appended to an E/M service. • The procedure code should be submitted on the claim form once and then listed again on a separate line with the appropriate modifier appended.
77	Repeat procedure by another physician or other qualified health care professional	Append modifier only when a basic procedure or service is repeated by another physician or other qualified health care professional subsequent to the original procedure or service. • Procedure must be the same procedure. • This modifier should not be appended to an E/M service.
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	Append modifier if necessary, to indicate another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). • Should be used to identify a related procedure requiring a return trip to the operating/procedure room, on the same day as or within the postoperative period of a major or minor surgery. • Append if used to treat the member for complications resulting from the original surgery.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
79	Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period	Append modifier to indicate the performance of a procedure or service during the postoperative period is unrelated to the original procedure. • Not a repeat procedure on the same day. • Modifier re-sets global period. A new post-operative period will begin when an unrelated procedure is billed.
80	Assistant surgeon	Append modifier to those surgical procedures where an assistant surgeon is warranted. • Physicians acting as assistants cannot bill as co-surgeons. • Physician is assisting at surgery.
81	Minimum assistant surgeon	Append modifier to those surgical procedures where minimum surgical assistant services are warranted. • Physician acting as an assistant that does not participate in the entire procedure; provides minimal assistance to the primary surgeon. • Physicians acting as assistants cannot bill as co-surgeons.
82	Assistant surgeon (When qualified resident surgeon not available)	Append modifiers to those surgical procedures where an assistant surgeon is warranted when a qualified resident surgeon is not available. Physicians acting as assistants cannot bill as co-surgeons.
91	Repeat clinical diagnostic laboratory tests	Append modifier to report repeat clinical diagnostic lab tests or studies performed on the same day on the same member to obtain subsequent test results. • Should not be submitted when a test is rerun to confirm the initial results due to an issue with the specimen, equipment or for any other reason when the one-time reportable result was all that was required.
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system	Append to synchronous telemedicine services rendered via real-time interactive audio and video telecommunications system. • Modifier 95 is applicable to certain codes that can be found in AMA, CPT documents. Check current CPT documents for the appendix on **CPT Codes That May Be Used for Synchronous Telemedicine Services**. • Codes that are appropriate for use with modifier 95 are indicated with a star (★) throughout the AMA, CPT codebook.
AA	Anesthesia services performed personally by the Anesthesiologist	Append modifier when performed only by the Anesthesiologist. • Modifier information is billed by an Anesthesiologist MD.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	Append modifier when service was supervised by an Anesthesiologist. • Modifier information is billed by an Anesthesiologist MD.
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	Append modifier when non-physician practitioners (PA, APN, CRNFA or LSA) are assisting surgeons as a surgical assistant. The assistant surgeon provides more than ancillary services. Append the modifier when the supervising physician is billing on behalf of a PA, APN, or CRNFA or LSA including that provider's National Provider Identification (NPI) number. Append modifier to PA, APN, CRNFA or LSA claim submissions when billing their own NPI.
ER	Items and services furnished by a provider-based, off campus emergency department	Append modifier when items or services are furnished by a provider-based off-campus emergency department. • Should be appended with every claim line for outpatient hospital services furnished in an off-campus provider-based emergency department. • Provider-based off-campus emergency departments that meet the definition of a "dedicated emergency department", defined in 42 Code of Federal Regulations (CFR) 489.24 under the Emergency Medical Treatment and Labor Act (EMTALA) regulations are required to append modifier ER.
FS	Split (or shared) evaluation and management visit	Append modifier on claims to identify a split or shared visit. • Documentation must identify the two providers who performed the visit and include a date and signature by the provider who provided the substantive portion.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
FT	Unrelated evaluation and management visit during a postoperative period, or on the same day as a procedure or another E/M visit.	Unrelated critical care evaluation and management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit (within the global surgical period but, is unrelated to the procedure, or when one or more additional E/M visits furnished on the same day are unrelated). The members medical records must clearly document critical care rendered was unrelated to the procedure. (Note, modifier -FT may only be appended to critical care code(s).)
G0	Telehealth services for diagnosis, evaluation, or treatment of symptoms of an acute stroke	Append modifier to report telehealth services for diagnosis, evaluation, or treatment of systems of an acute stroke.
GQ	Via asynchronous telecommunications system	Append modifier to report use of an asynchronous telecommunications system. • Should only be used to indicate interactive telehealth services.
GT	Via interactive audio and video telecommunications system	Append modifier to report interactive audio and video telecommunications system. • Should only be used to indicate interactive telehealth services.
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure	Append modifier in the second modifier position when a pricing anesthesia modifier accompanies it in the first modifier position and the service rendered is monitored anesthesia care (MAC).
G9	Monitored anesthesia care (MAC) for a patient who as a history of severe cardiopulmonary condition	Append modifier in the second modifier position when a pricing anesthesia modifier accompanies it in the first modifier position and the service rendered is monitored anesthesia care (MAC).
HM	Less than bachelor's degree level	Append modifier for Applied Behavioral Analysis (ABA) behavior health services when the rendering provider has less educational attainment of a bachelor's degree and no Registered Behavior Technician (RBT) certification. • Modifier is used to indicate the level of education, training, and certification of the rendering provider when billing CPT code 97153.
HN	Bachelor's degree level	Append modifier for Applied Behavioral Analysis (ABA) behavioral health services when the rendering provider is a Registered Behavior Technician (RBT), Board Certified Assistant Behavior Analyst (BCaBA) or a clinician with a bachelor's degree. • Modifier is used to indicate the level of education, training, and certification of the rendering provider when billing CPT code 97153. Note, if modifier HN is not appended, reimbursement will default to modifier HM.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
HO	Master's degree level	Append modifier for Applied Behavioral Analysis (ABA) behavioral health services when the rendering provider is a Board-Certified Behavior Analyst (BCBA), Board Certified Behavior Analyst-Doctoral (BCBA-D) or a clinician with a master's degree or higher education. • Modifier is used to indicate the level of education, training, and certification of the rendering provider when billing CPT code 97153. Note, if modifier HO is not appended, reimbursement will default to modifier HM.
JW	Drug amount discarded/not administered to any patient	Append modifier to report the amount of unused drugs or biologicals from single use vials or single use packages that is discarded/not administered to the member.
NU	New equipment	Append modifier for new DME equipment.
PN	Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital	Append modifier for non-excepted items and services provided at an off-campus, outpatient, provider-based department of a hospital. • Append modifier on each claim line for non-excepted items and services, including but not limited to, separately payable drugs, clinical laboratory tests and therapy services.
PO	Excepted service provided at an off-campus, outpatient, provider-based department of a hospital	Append modifier for services, procedures and/or surgeries provided at off-campus provider-based outpatient departments. • Append modifier on each claim line for outpatient hospital services furnished in an off-campus provider-based department of a hospital.
PT	Colorectal cancer screening test; converted to diagnostic test or other procedure	Append modifier to report colorectal cancer screening services converted to a diagnostic test or other procedure.
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	Append modifier when service was supervised by an Anesthesiologist. • Modifier information is billed by an Anesthesiologist MD.
QS	Monitored anesthesiology care service (MAC)	Append modifier in the second modifier position when a pricing anesthesia modifier accompanies it in the first modifier position and the service rendered is monitored anesthesia care (MAC).
QX	CRNA service: with medical direction by a physician	Append modifier when CRNA or AA (Anesthesiologist Assistant) provides service under medical direction from a physician. • Modifier information is billed by a CRNA/AA.

MODIFIER	DESCRIPTION	WHEN TO APPEND A MODIFIER
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an Anesthesiologist	Append modifier when one CRNA or AA is under the direction of the Anesthesiologist. • Modifier information is billed by an Anesthesiologist MD.
QZ	CRNA service: without medical direction by a physician	Append modifier when CRNA provides service without medical direction by a physician. • Modifier information is billed by a CRNA.
RR	Rental	Append modifier for DME rentals. • One unit of service is billed per monthly period unless classified as a daily rental.
SH	Second concurrently administered infusion therapy	Append modifier to report second concurrent administered infusion therapy.
SJ	Third or more concurrently administered infusion therapy	Services that are submitted with modifier SJ appended to them will **not** be reimbursed. This modifier denotes a third or more concurrent administered infusion therapy.
UE	Used durable medical equipment	Append modifier for used DME equipment.
XE	Separate encounter	In order to bill this modifier, documentation must support the service is distinct because it occurred during a separate encounter. • Refer to CMS guidelines.
XP	Separate Practitioner	In order to bill this modifier, documentation must support the service is distinct because it was performed by a different practitioner. • Refer to CMS guidelines.
XS	Separate structure	In order to bill this modifier, documentation must support the service is distinct because it was performed on a separate organ/structure. • Refer to CMS guidelines.
XU	Unusual non-overlapping service	In order to bill this modifier, documentation must support the use of a service is distinct because it does not overlap usual components of the main service. • Refer to CMS guidelines.

Anatomical Modifiers

Claims edit software validates the claim lines procedure and modifier against a set of required modifiers by procedure. If a procedure with a required modifier does not have the modifier appended, the claim will deny. If an anatomical modifier is necessary to differentiate right or left and is not appended, the claim will be denied. Likewise, if a modifier is appended to a procedure code that does not match the appropriate anatomical site, the claim will be denied. CMS has identified a set of anatomical modifiers to facilitate correct coding for claims processing. Providers should append the modifier in box24D of the CMS 1500 claim form, or electronically report the first modifier in SV101-3; use the additional fields SV101-4, SV101-5 or SV101-6 if needed for additional modifiers relevant to the procedure code on the service line. The anatomical modifiers are:

Modifier	Modifier Description
E1-E4	Eyelids
FA, F1-F9	Fingers
TA, T1-T9	Toes
LC	Left circumflex, coronary artery
LD	Left anterior descending coronary artery
LM	Left main coronary artery
LT	Left
RI	Ramus intermedius
RC	Right coronary artery
RT	Right
50	Bilateral procedure

HCPCS modifiers should not be submitted on claims with Physician Quality Reporting Initiative (PQRI) CPT Category II codes. In this case, providers should ensure the appropriate billing of Category II modifiers.

For additional information regarding modifier reimbursement percentages, participating providers should refer to the plan's provider website or contact a Network Representative.

Additional Resources:

CPCP006 Preventive Services Policy

CPCP009 Co-Surgeon/Team Surgeon Modifiers

CPCP010 Anesthesia Clinical Payment and Coding Information

CPCP011 Applied Behavior Analysis

CPCP013 Increased Procedural Services (Modifier 22)

CPCP014 Global Surgical Package-Professional Provider

CPCP015 Multiple Surgical Procedures-Professional Provider Services

CPCP017 Wasted/Discarded Drugs & Biologicals Policy

CPCP019 Home Infusion

CPCP021 Laboratory Panel Billing

CPCP022 Pneumatic Compression Devices- Outpatient Use

CPCP024 Evaluation and Management (E/M) Coding- Professional Provider Services

CPCP026 Therapeutic, Prophylactic and Diagnostic Injection and Infusion Coding

CPCP032 Intraoperative Neurophysiology Monitoring (IONM) Coding and Reimbursement Guideline

CPCP033 Telemedicine and Telehealth Services

CPCP036 Paravertebral Facet Injection Procedure Coding and Billing Policy

References:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Healthcare Common Procedure Coding Systems (HCPSC)

Policy Update History:

Approval Date	Description
11/27/2018	New policy
02/28/2020	Annual Review, Disclaimer Update
03/31/2021	Annual Review
04/08/2022	Annual Review
05/13/2022	Additional revisions
03/17/2023	Coding and Recommendation Updates