Reimbursement Policy

Modifiers

Policy Number: 4.23
Version Number: 4
Version Effective Date: 08/01/2021

Product Applicability	☐ **All Plan⁺ Products**
Well Sense Health Plan	**Boston Medical Center HealthNet Plan**
☐ Well Sense Health Plan	☒ MassHealth MCO ☒ MassHealth ACO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.bmchp.org.

⁺ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Definitions

Modifier – a two-digit numeric or alphanumeric character that is used to indicate that a service or procedure that has been performed has been altered by a specific circumstance without changing the definition of the code.

Provider Reimbursement

Some modifiers directly affect reimbursement and some modifiers are used for informational purposes only. Refer to the most updated industry standard coding guidelines and Centers for Medicare and Medicaid Services guidelines for a complete list of modifiers and their usage. The following table describes the most common modifiers with an impact on reimbursement and the rate at which services reported with these modifiers will be paid.

Modifier	Description	Applicable Providers	% of Allowable
Professional/Technical Components			
TC	Technical Component	Professional	Fee Schedule Amount
26	Professional Component	Professional	Fee Schedule Amount
Global Surgery			
54	Surgical Care Only	Professional	85%
55	Postoperative Management Only	Professional	15%
78	Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period	Professional	80%
Assist/Co/Team Surgeons			
62	Two Surgeons	Professional	Each surgeon receives 57.5% of global fee schedule amount
66	Surgical team	Professional	By report
80	Assistant Surgeon	Professional	15%
81	Minimum Assistant Surgeon	Professional	15%
82	Assistant Surgeon (when qualified resident surgeon not available)	Professional	15%
AS	Nurse practitioner, Physician assistant, or clinical nurse specialist services for assistant at surgery	Professional	15%
Discontinued/Reduced Services			
52	Reduced Services	Professional or Facility	25%
53	Discontinued Service	Professional	25%
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia	Facility	50%

74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia	Facility	100%
Anesthesia			
AA	Anesthesia services performed personally by anesthesiologist	Professional	100%
AD	Medical supervision for more than four concurrent anesthesia procedures is provided	Professional	Individual Consideration
QK	Medical direction by a physician of two, three or four concurrent anesthesia procedures. Use to indicate physician medical direction of multiple CRNAs.	Professional	50%
QX	CRNA anesthesia services with medical direction by a physician and CRNA is not employed by the facility	Professional	50%
QY	Medical direction of one CRNA by physician. Use to indicate physician medical direction of one CRNA.	Professional	50%
QZ	Administered by CRNA without medical direction and CRNA is not employed by the facility	Professional	100%
Same Day Separate & Distinct Procedural Services			
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter (This modifier should only be used to describe separate encounters on the same date of service.)	Professional or Facility	See Same Day Separate and Distinct Procedural Services Modifier Details
XP	Separate Practitioner, a service that is distinct because it was performed by a different practitioner	Professional or Facility	
XS	Separate Structure, a service that is distinct because it was performed on a separate organ/structure	Professional or Facility	
XU	Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service	Professional or Facility	
59	Distinct procedural service	Professional or Facility	
Non-Physician Practitioners			
SA	Nurse Practitioner (NP) rendering service in collaboration with a physician. This modifier is to be applied to service codes billed by a physician that were performed by a certified nurse practitioner employed by the physician. A certified nurse practitioner billing under	Professional	85%

	his/her own individual provider number, or a group practice, should not use this modifier.		
SB	Certified Nurse Midwife(CNM)	Professional	85%
HN	Bachelors level degree (Use for Physician Assistant)	Professional	85%
Other			
22	Increased Procedural Services	Professional	Individual Consideration
24	Unrelated E/M service by same physician during postoperative period	Professional	100%
25	Significant, separately identifiable E&M service by the same physician on the same day as the procedure or other service	Professional or Facility	100%
50	Bilateral Procedure	Professional or Facility	150%
51	Multiple Procedures	Professional or Facility	50%
91	Repeat clinical diagnostic laboratory test	Professional or Facility	100%
JW	Drug/Biological Amount Discarded/Not Administered To Any Patient	Professional or Facility	Priced at $0
AH	Clinical psychologist	Professional	100%
AJ	Clinical social worker	Professional	75%
SL	State supplied vaccine	Professional or Facility	Priced at $0 for vaccine only

Modifiers for Tobacco Cessation Services

The following modifiers are used in combination with **Service Code 99407** to report tobacco-cessation counseling. Service Code 99407 (smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes) may also be billed without a modifier to report an individual smoking and tobacco-use cessation counseling visit of at least 30 minutes.

Tobacco-Cessation Modifier	Description	Applicable Providers	% of Allowable
HQ	Group counseling, at least 60–90 minutes in duration, provided by a physician	Professional	100%
TD	Individual counseling provided by a registered nurse (RN)	Professional	100%
TF	Individual counseling, intermediate level of care (intake/assessment counseling, at least 45 minutes in duration) provided by a physician	Professional	100%

Tobacco-Cessation Modifier	Description	Applicable Providers	% of Allowable
U1	Individual counseling services provided by a tobacco-cessation counselor	Professional	100%
U2	Individual intake/assessment counseling, at least 45 minutes in duration, provided by a nurse practitioner, nurse midwife, physician assistant, registered nurse, or a tobacco-cessation counselor, under the supervision of a physician	Professional	100%
U3	Group counseling, at least 60-90 minutes in duration, provided by a nurse practitioner, nurse midwife, physician assistant, registered nurse, or a tobacco-cessation counselor, under the supervision of a physician	Professional	100%

Same Day - Separate & Distinct Procedural Service Modifiers

Modifiers to report same day, separate and distinct procedural services must be reported to identify procedures and/or services that are distinct and unrelated. Medical record documentation must clearly support the different session and/or procedure, not normally performed on the same day by the same physician and/or group.

The Plan requires the XE, XP, XS, XU modifiers to report same day, distinct procedural services. These modifiers define more specific, same day, distinct services associated with modifier 59. The Plan will continue to recognize Modifier 59, however per Current Procedural Terminology guidelines, modifier 59 should NOT be used when a more descriptive modifier is available. The -X{EPSU} modifiers are more selective versions of the -59 modifier and therefore incorrect billing to report both modifiers on the same line.

State Supplied Vaccines

Vaccines supplied by the state of Massachusetts at no charge to providers must be reported with modifier SL on both the vaccination and administration code. The Plan does not reimburse providers for state supplied vaccines.

Drug Waste/Discarded Drugs and Biologicals

The Plan does not reimburse providers for drug waste. Providers are required to report the JW modifier on claims with unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. Providers should report drug waste on a separate and distinct claim line with the procedure code along with modifier JW. Drug waste will be denied as not reimbursable.

Canceled Procedures

The Plan will not reimburse a provider for any surgical procedures that are canceled or postponed, for any reason, before the procedure is initiated.

Other Modifier Related Policies

There may be instances where certain services may require the Plan to make exceptional accommodations by utilizing modifiers. In these instances, the Plan will give specific instructions on how to bill the applicable services. Modifier billing instructions on other Plan policies/network notifications will always supersede the preceding table. This table has been created as a guideline for services without specific billing instructions.

Modifier Editing

The Plan edits for inappropriate/invalid use of modifiers, repeat modifiers and inappropriate modifier combinations in accordance with current coding principles based on Centers for Medicare & Medicaid (CMS) guidelines, professional medical society guidance, the National Correct Coding Initiative and the AMA CPT manual.

Provide should include all required modifiers for a CPT/HCPCS when billing the Plan. Providers should also bill with valid/appropriate modifiers for the CPT/HCPCS and valid/appropriate modifier combinations to avoid Plan denials.

Repeat laboratory test modifier 91 is added only when additional test results are to be obtained subsequent to the initial administration or performance of the same test(s) on the same day. The Plan will deny claims submitted with modifier 91 and there is no initial administration or performance of the same test on the same date of service.

Please reference the Plan's reimbursement policy General Clinical Editing and Payment Accuracy Review Guidelines, 4.108 for additional guidance on the Plan's claim editing for modifier usage.

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
02/19/2019	05/15/2019	Payment Policy	Payment Policy Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
03/16/2021	Removed modifier 56 and revised percentage for modifier 54	04/01/2021	Payment Policy Committee
04/20/2021	Revised language regarding Plan requirement for duplicate modifier billing	05/15/2021	Payment Policy Committee
07/20/2021	Annual review, added language regarding multiple modifiers,	08/01/2021	Payment Policy Committee

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Policy Revisions History			
	added JW and 91 to the coding table.		

Other Applicable Policies

Reimbursement Policies

- Bilateral and Multiple Procedure Reductions – Professional, 4.607
- General Billing and Coding Guidelines, 4.31
- Outpatient Hospital, 4.17
- Home Infusion including Parenteral/Tube Fed Enteral Nutrition Therapy, 4.121
- Free Standing Surgical Facility, 4.114
- Anesthesia, 4.103
- General Clinical Editing and Payment Accuracy Review Guidelines, 4.108
- Physician and Non Physician Practitioner Services, 4.608
- Provider Preventable Conditions and Serious Reportable Events, 4.610

References

- Medicare Claims Processing Manual Chapter 12 - Physicians/Non-physician Practitioners
- Medicare Claims Processing Manual Chapter 13 - Radiology Services and Other Diagnostic Procedures
- Medicare Claims Processing Manual Chapter 23 - Fee Schedule Administration and Coding Requirements
- CMS National Physician Fee Schedule Relative Value File

Disclaimer Information

This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.