

Reimbursement Policy

Modifiers

Policy Number: SCO 4.23

Version Number: 3

Version Effective Date: 05/15/2021

Product Applicability

All Plan⁺ Products

Well Sense Health Plan

Well Sense Health Plan

Boston Medical Center HealthNet 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.

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.

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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			
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%
54	Surgical Care Only	Professional	Reimbursed according to CMS guidelines. Carrier priced codes or codes without an established Medicare rate will be reimbursed 85%.
55	Postoperative Management Only	Professional	Reimbursed according to CMS guidelines. Carrier priced codes or codes without an established Medicare rate will be reimbursed 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	Only the Intraoperative percentage of the service is reimbursed
79	Unrelated procedure or service by same physician during post-operative period	Professional	100%
Assist/Co/Team Surgeons			
62	Two Surgeons	Professional	Each surgeon receives 62.5% of global fee schedule amount
66	Surgical team	Professional	By report
80	Assistant Surgeon	Professional	16%
81	Minimum Assistant Surgeon	Professional	16%
82	Assistant Surgeon (when qualified resident surgeon not available)	Professional	16%

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Modifier	Description	Applicable Providers	% of Allowable
AS	Nurse practitioner, Physician assistant, or clinical nurse specialist services for assistant at surgery	Professional	16%
Discontinued/Reduced Services			
52	Reduced Services	Professional or Facility	50%
53	Discontinued Service	Professional	Individual Consideration
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	

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Modifier	Description	Applicable Providers	% of Allowable
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	Professional	85%
SB	Certified Nurse Midwife(CNM)	Professional	100%
Laboratory Services			
FX	X-ray taken using film	Professional	Reduces the technical component's allowed amount by 20%
FY	X-ray taken using computed radiography	Professional	93%
Other			
22	Increased Procedural Services	Professional	Individual Consideration
50	Bilateral Procedure	Professional or Facility	150%
51	Multiple Procedures	Professional or Facility	50%
SL	State supplied vaccine	Professional or Facility	Priced at \$0 for vaccine only
AH	Clinical psychologist	Professional	100%
AJ	Clinical social worker	Professional	75%

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

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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.

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.

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
11/11/2015	01/01/2016	Payment Policy	Payment Policy Committee

Policy Revisions History			
Review Date	Summary of Revisions	Revision Effective Date	Approved by
08/18/2020	Annual Review; Updated logo and product applicability box	10/01/2020	Payment policy Committee
04/20/2021	Revised language for Plan billing requirements regarding duplicate modifier	05/15/2021	Payment Policy Committee

Other Applicable Policies

- Bilateral and Multiple Procedure Reductions – Professional, SCO 4.607
- General Billing and Coding Guidelines, SCO 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, SCO 4.108
- Physician and Non Physician Practitioner Services, SCO 4.608
- Ambulance, SCO 4.113
- Provider Preventable Conditions and Serious Reportable Events, SCO 4.610

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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.

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