

MODIFIERS

Policy

NHP accepts standard CPT and HCPCS modifiers submitted in accordance with the AMA CPT and CMS guidelines.

Definition

Modifier: A two digit alpha or numeric code indicating that a service or procedure was altered in some way from the stated code descriptor without changing the definition.

CPT Modifiers Applicable To Guideline

Please consult the most current CPT guidelines for appropriate modifier usage.

Modifier	Descriptor	Reimbursement Impact	Comments
22	Increased procedural services	120% of fee schedule allowable after medical record review	Submit medical records
23	Unusual anesthesia		
24	Unrelated E & M service by same physician during post-op period		
25	Significant, separately identifiable E & M service by same physician on same day of procedure or service	50% of fee schedule allowable	
26	Professional component	Fee schedule	For CMS identified codes with separate professional and technical components
32	Mandated Services	No additional reimbursement	Services mandated by an external agency not the responsibility of NHP
33	Preventive Service		When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in the preventive services mandates (legislative or regulatory), the service may be identified by appending modifier 33, Preventive Service, to the service. For separately reported services specifically identified as preventive,

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			Modifier 33 should not be used. Please refer to the Preventive Services: U.S. Preventive Services Task Force Recommendations Provider Payment Guideline.
47	Anesthesia by Surgeon	No additional reimbursement	No additional reimbursement for anesthesia by a surgeon, assistant surgeon, nursing staff, or any other non-anesthesiologist professional during a procedure
50	Bilateral procedure	150% of fee schedule allowable	Bill on one claim line, with one unit in the units field, reflecting both components of the bilateral procedure
51	Multiple procedures	50% of the fee schedule allowable, unless otherwise specified	
52	Reduced Services	50% of fee schedule allowable	Submit pertinent documentation
53	Discontinued procedure	25% of fee schedule allowable	Submit pertinent documentation
54	Surgical care, only	75% of fee schedule allowable	
55	Post-op management, only	25% of fee schedule allowable	Submit with CPT code representing the procedure performed.
56	Pre-op management, only		
57	Decision for surgery		
58	Staged or related procedure or service by same physician during post-op period		
59	Distinct procedural service		
62	Two Surgeons	62.5% fee schedule allowable	See modifier 80-82 comments below.
63	Procedure performed on infants		
66	Surgical Team	Individual consideration after medical review of op notes	Submit operative notes
73*	Discontinued outpatient / ASC procedure prior to anesthesia administration	50% fee schedule allowable	For ASC, hospital outpatient use, only
74*	Discontinued outpatient / ASC procedure after anesthesia administration	50% of fee schedule allowable	For ASC, hospital outpatient use, only
76	Repeat procedure by same physician		
77	Repeat procedure by another physician		

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Modifier	Descriptor	Reimbursement Impact	Comments
78	Unplanned return to OR for related procedure during post-op period	75% of fee schedule allowable	
79	Unrelated procedure/service by same physician during post-op period		
80	Assistant Surgeon	16% fee schedule allowable	In alignment with the American College of Surgeons (ACOS) and CMS, NHP will consider reimbursement for services of multiple surgeons when the procedure warrants
81	Minimum Assistant Surgeon	16% fee schedule allowable	
82	Assistant Surgeon (when qualified resident surgeon not available)	16 % fee schedule allowable	
90	Reference (outside) laboratory		
91	Repeat clinical laboratory diagnostic test		
92	Alternative laboratory platform testing		Can only be appended to HIV testing codes 86701-86703 for a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber.
99	Multiple modifiers		

** Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use, ONLY*

Genetic Testing Code Modifiers: REQUIRED

Appendix I, found in the appendices section of the CPT manual, lists modifiers for molecular genetics testing to enable providers to submit more complete and specific information for claims adjudication, as they provide more information on the purpose for molecular laboratory procedures without altering test descriptors. The modifier system is classified by gene mutation. The first (numeric) digit indicates the disease category, and the second (alpha) digit denotes gene type.

Code	Descriptor	Comments
Various	Genetic Testing Code Modifiers	<p>Reference Appendix I of the current year CPT Manual for a complete listing.</p> <p>Report with molecular laboratory procedures related to genetic testing.</p> <p>Introductory guidelines in the molecular diagnostic and molecular cytogenic code sections of the CPT codebook provide further guidance in interpretation and application of genetic testing modifiers.</p>

HCPCS Level II Modifiers Applicable to Guideline

The following lists are not all-inclusive. Please refer to the program specific guidelines (E.g. Home Health, Community Medical Alliance,) for appropriate modifier usage, and consult the most current HCPCS manual for a complete listing of current modifiers.

SRE (Serious Reportable Events) Specific Modifiers: REQUIRED

Modifier	Descriptor
PA	Surgical or other invasive procedure on wrong body part
PB	Surgical or other invasive procedure on wrong patient
PC	Wrong surgery or other invasive procedure on patient

Miscellaneous HCPCS Level II Modifiers

Modifier	Descriptor	Comments
AI	Principal Physician of Record	Append this modifier to the initial hospital care or initial nursing facility care E/M code to determine the admitting physician of record . For operational purposes this modifier will distinguish the admitting physician of record who oversees the patient's care from other physicians who may furnish specialty care.
AS	Physician assistant, nurse practitioner, or clinical nurse specialist as assistant-at-surgery	In alignment with the American College of Surgeons (ACOS) and CMS, NHP will consider reimbursement for services of multiple surgeons when the procedure warrants.
GC	Resident/teaching physician service	
GE	Resident primary care exception	
SL	State Supplied Vaccine	No reimbursement
TC	Technical component	Fee schedule allowable for CMS identified codes with separate professional and technical components

Anesthesia Specific Modifiers

Modifier	Descriptor	Comments
AA	Anesthesia services performed personally by anesthesiologist	100% allowable
AD	Medical supervision by physician; more than 4 concurrent anesthesia procedures	3 ASA base units at anesthesia fee schedule allowable
P1-P6	Physical Status Modifiers	No additional reimbursement

Modifier	Descriptor	Comments
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures	50% anesthesia fee schedule allowable
QS	Monitored anesthesia care (MAC) by anesthesiologist	
QX	CRNA service with medical direction by a physician	50% anesthesia fee schedule allowable
QY	Medical direction of 1 CRNA by anesthesiologist	50% anesthesia fee schedule allowable
QZ	CRNA service without medical direction by a physician	Not a Covered Benefit

Common Site Specific Modifiers

Use to differentiate anatomical sites for multiple procedures.

Modifier	Descriptor
E1-E4	Eyelids
FA-F9	Fingers
TA-T9	Toes
RT	Right
LT	Left
LD	Left anterior descending coronary artery
RC	Right coronary artery

Common DME Modifiers

Use to differentiate anatomic site for equipment/supplies, and to describe acquisition/payment methodology

Modifier	Descriptor	Comments
KR	Rental item, partial month	Submit claim reflecting from and to date. Reimbursement based on a % of monthly rental prorated by days billed.
LT	Left side	
MS	6 months maintenance / servicing fee, reasonable necessary parts and labor	
NU	New equipment	
RR	Rental (DME)	
RT	Right side	

Common Early Intervention Modifiers

Modifier	Descriptor
AH	Clinical psychologist
AJ	Clinical social worker
GN	OP speech language service
HN	Bachelors degree level
TD	RN
TE	LPN/LVN
TJ	Child/adolescent program group

Developmental Testing Modifiers

Submit one of the following modifiers when submitting CPT 96110 in conjunction with an office visit CPT code.

Modifier	Descriptor	Comments
U1	Medicaid Level of Care: Completed behavioral health screening using a standardized behavioral health screening tool with no behavioral health need identified when administered by a physician, independent nurse midwife or independent nurse practitioner.	For separate reimbursement of CPT 96110 when submitted in conjunction with an office visit code, append the appropriate "U" modifier to 96110. If a "U" modifier is not appended to 96110, the code will be reimbursed at \$0.00.
U2	Medicaid Level of Care: Completed behavioral health screening using a standardized behavioral health screening tool and a behavioral health need was identified when administered by a physician, independent nurse midwife or independent nurse practitioner.	Please refer to the Preventive Services: U.S. Preventive Services Task Force Recommendations Provider Payment Guideline.
U3	Medicaid Level of Care: Completed behavioral health screening using a standardized behavioral health screening tool with no behavioral health need identified when administered by a nurse midwife employed by a physician.	
U4	Medicaid Level of Care: Completed behavioral health screening using a standardized behavioral health screening tool and a behavioral health need was identified when administered by a nurse	

	midwife employed by a physician.	
U5	Medicaid Level of Care: Completed behavioral health screening using a standardized behavioral health screening tool with no behavioral health need identified when administered by a nurse practitioner employed by a physician.	
U6	Medicaid Level of Care: Completed behavioral health screening using a standardized behavioral health screening tool and a behavioral health need was identified when administered by a nurse practitioner employed by a physician.	
U7	Medicaid Level of Care: Completed behavioral health screening using a standardized behavioral health screening tool with no behavioral health need identified when administered by a physician assistant employed by a physician.	
U8	Medicaid Level of Care: Completed a behavioral health screening using a standardized behavioral health screening tool and a behavioral health need was identified when administered by a physician assistant employed by a physician.	

Ambulance Origin and Destination Most Common Modifier Components

Use in combination to make a two digit modifier to report services.

- The first digit indicates the transport place of origin.
- The second digit indicates the destination.

Modifier	Descriptor	
D	Diagnostic/therapeutic site other than "P" or "H"	
E	Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)	
G	Hospital-based dialysis facility (hospital or hospital related)	
H	Hospital	
I	Site of transfer (e.g. airport or helicopter pad) between types of ambulance	
J	Nonhospital-based dialysis facility	
N	Skilled nursing facility (SNF)	
P	Physician's office (includes HMO nonhospital facility, clinic, etc.)	
R	Residence	
S	Scene of accident or acute event	
X*	Intermediate stop at physician's office enroute to hospital (includes HMO nonhospital facility, clinic, etc.)	
Modifier	Descriptor	Comments
GM	Multiple patients on one ambulance trip	Reimbursed at 50% allowable <i>if</i> billed on separate claims for multiple NHP members. No reduction if billed as single claim under one NHP member.

**Modifier X can only be used as a destination code in the second position of a modifier.*

Related NHP Payment Guidelines

Please refer to the list of Provider Payment Guidelines found at:

http://www.nhp.org/pages/providers_adminresources_paymentguidelines.aspx

A sample of guideline titles follows:

NHP Anesthesia Services Provider Payment Guideline

NHP Coding Provider Payment Guideline

NHP Evaluation and Management Provider Payment Guideline

NHP Preventive Services: U.S. Preventive Services Task Force Recommendations Provider Payment Guideline

NHP Vaccine and Immunization Provider Payment Guideline

References

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Publication History

Topic: Modifiers	Owner: Provider Network Management
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2009/07/24 *Original documentation*

2011/05/17 *Modifies added, genetic testing code comments, references and disclaimer updated*

2011 11/01 *Added AI modifier, updated modifier table reimbursement*

2011 12/20 *Modifier 59 updated*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Neighborhood Health Plan utilizes McKesson's claims editing software, ClaimCheck, a clinically oriented, automated program that identifies the "appropriate set" of procedures eligible for provider reimbursement by analyzing the current and historical procedure codes billed on a single date of service and/or multiple dates of service, and also audits across dates of service to identify the unbundling of pre and post-operative care. Please refer to Neighborhood Health Plan's Provider Manual Billing Guidelines section for additional information on NHP's billing guidelines and administration policies. Questions may be directed to Provider Network Management at prweb@nhp.org