



## REIMBURSEMENT POLICY STATEMENT OHIO MEDICARE ADVANTAGE

Policy Name		Policy Number	Effective Date
Reimbursement Modifiers		PY-0716	09/01/2019- 03/31/2022
Policy Type			
Medical	Administrative	Pharmacy	REIMBURSEMENT

Reimbursement Policy Statement: Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

### Table of Contents

Reimbursement Policy Statement .....	1
A. Subject .....	2
B. Background .....	2
C. Definitions .....	2
D. Policy .....	2
E. Conditions of Coverage .....	10
F. Related Policies/Rules .....	10
G. Review/Revision History .....	10
H. References .....	10



## A. Subject

### Reimbursement Modifiers

## B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Modifiers can be used to further describe a product or service rendered. Some modifiers are for informational purposes only, while other modifiers are used to report additional information, to the code description, of the product or service. Although CareSource accepts the use of modifiers specific to this policy, not all modifiers are included within this policy. The modifiers included within this policy are those modifiers that affect the reimbursement of a service. Using a modifier inappropriately can result in the denial of a claim or an incorrect reimbursement for a product or service. CareSource may verify the use of any modifier through post-payment audit. All information regarding the use of these modifiers must be made available upon CareSource's request. **In the event of any conflict between this policy and a provider's contract with CareSource, the provider's contract will be the governing document.**

## C. Definitions

- **Current Procedural Terminology (CPT)** - codes that are issued, updated and maintained by the American Medical Association (AMA) that provides a standard language for coding and billing medical services and procedures.
- **Healthcare Common Procedure Coding System (HCPCS)** - codes that are issued, updated and maintained by the American Medical Association (AMA) that provides a standard language for coding and billing of products, supplies, and services not included in the CPT codes.
- **Modifier** - two-character codes used along with a CPT or HCPCS code to provide additional information about the service or supply rendered.

## D. Policy

### I. Modifier 22 - Increased Procedural Services

- A. Modifier 22 is used to report services (surgical or nonsurgical) when the work required to provide a service is substantially greater than typically required. The extra work may be identified by appending modifier 22 to the usual procedure code.
- B. Procedure codes with modifier 22 appended **may** be reimbursed **up to** 120% of the fee schedule amount.

**Note:** This modifier is not appended to E/M services (99201-99499). Claims for 99201-99499 with modifier 22 will be denied. Medical records ARE required with the



claim and must support the use of this modifier. Claims with procedures including 22 and no supporting documentation will be denied.

## II. Modifier 50 - Bilateral Procedures

- A. Professional Claims Only – Append modifier 50 to the appropriate unilateral code on a single claim line and indicate 1 unit in the unit field of that claim line.
- B. Modifier 50 applies to surgical procedures (CPT codes 10040-69990) and to radiology procedures performed bilaterally.
- C. Applies to any bilateral procedure performed on both sides at the same session.
- D. The use of modifier 50 is **NOT** appropriate in the following situations:
  - 1. Using modifier 50 on a bilateral procedure performed on different areas of the right and left sides of the body.
  - 2. Appending modifier 50 to a procedure code that is defined by CPT as primarily bilateral or a bilateral service.
  - 3. Appending modifier 50 to a surgical CPT code, the description of which contains the words "one" or "both."
- E. Do not report two line items to indicate a bilateral procedure.
- F. Procedure code with modifier 50 appended will reimburse 1 unit at 150% of the fee schedule amount.

## III. Modifier 51 - Multiple Procedures

- A. Modifier 51 is used to report multiple procedures, other than E/M services, are performed at the same session by the same individual, the primary procedure or service is reported as listed.
- B. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).
- C. Modifier 51 should not be appended to designated "add-on" codes.
- D. Procedure code with modifier 51 appended will reimburse 50% of the fee listed on the Medicaid Physician Fee Schedule for the service.

## IV. Modifier 52 - Reduced services

- A. Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional.
  - 1. Modifier 52 is used for reporting reduced services when the procedure was terminated **after** the patient was prepped and brought to the room where the service was to be performed.
- B. Modifier 52 may be used to report reduced radiology procedures.
  - 1. The correct reporting is to assign the CPT code to the extent of the procedure performed.
  - 2. This modifier is used only to report a radiology procedure that has been reduced when no other code exists to report what has been done.
  - 3. Report the intended code with modifier 52.
    - i. Example, if the planned procedure is a two-view chest x-ray and only one view of the chest is performed, do not report CPT code 71020-52 (for x-ray chest, two views-reduced service). Instead, report CPT code 71010 (x-ray chest, single view).
    - ii. Example, if a barium swallow is not completed because the patient cannot handle the barium, report CPT code (74270-52).
- C. Modifier 52 does not provide for reimbursement of an ineligible service.
- D. For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.
- E. Procedure code with modifier 52 appended will reimburse at 50% of the fee schedule amount.



**Note:** Medical records are not required with the claim, but must be available upon CareSource's request. Clinical information documented in the patient's records must support to use of this modifier. The extenuating circumstances preventing the completion of the procedure must also be documented

#### V. Modifier 53 - Discontinued Procedure

- A. Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure.
  - 1. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued **after** anesthesia is administered to the patient.
  - 2. Modifier 53 is used to indicate that the physician terminated a surgical/diagnostic procedure due to the patient's well-being.
- B. This modifier is **not** used to report an elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.
- C. Modifier 53 **cannot** be used when a laparoscopic or endoscopic procedure is converted to an open procedure.
- D. Modifier 53 **does not** provide for reimbursement of an ineligible service.
- E. Modifier 53 **cannot** be appended to E/M codes.
- F. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.
- G. Procedure code with modifier 53 appended will reimburse at 25% of the fee schedule amount.

**Note:** Medical records are not required with the claim, but must be available upon CareSource's request. Clinical information documented in the patient's records must support to use of this modifier. Documentation must include a statement indicating at what point the procedure was discontinued. The extenuating circumstances preventing the completion of the procedure must also be documented.

#### VI. Modifier 54 - Surgical Care Only

- A. Modifier 54 is reported when one physician performed a surgical procedure only; another physician provides the preoperative and/or postoperative management.
- B. Modifier 54 must only be appended to the surgical procedure code.
- C. Procedure code with modifier 54 appended will reimbursed at 70% of the fee schedule amount.

**Note:** Medical records are not required with the claim, but must be available upon CareSource's request. Clinical information documented in the patient's records must support to use of this modifier.

#### VII. Modifier 55 - Postoperative Management Only

- A. Modifier 55 is reported when 1 physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by appending modifier 55 to the procedure code.
- B. Modifiers 55 must only be appended to the surgical procedure code.
- C. Procedure code with modifier 55 appended will reimburse at 15% of the fee schedule amount.



**Note:** Medical records are not required with the claim, but must be available upon CareSource's request. Clinical information documented in the patient's records must support to use of this modifier.

**VIII. Modifier 56 - Preoperative Management Only**

- A. Modifier 56 is reported when 1 physician performed the preoperative care and evaluation and another physician performed the surgical procedure. Modifier 56 is appended to the surgical code.
- B. Modifiers 56 must only be appended to the surgical procedure code.
- C. Procedure code with modifier 56 appended will reimburse at 15% of the fee schedule amount.

**Note:** Medical records are not required with the claim, but must be available upon CareSource's request. Clinical information documented in the patient's records must support to use of this modifier.

**IX. Modifier 62 - Two Surgeons**

- A. Modifier 62 is reported when 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure.
  - 1. Each surgeon **must** report his/her distinct operative work by adding the modifier 62 to the procedure code and any associated add-on codes(s) for that procedure as long as both surgeons continue to work together as primary surgeons.
  - 2. Each surgeon **must** report the co-surgery once using the same procedure code. If additional procedure(s), including add-on procedures(s) are performed during the same surgical session, separate code(s) may also be reported without the modifier 62 added.
  - 3. If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with the modifier 80 or 82 added, as appropriate.
- B. Procedure code with modifier 62 appended will be reimbursed at 62.5% of the fee schedule amount.

**Note:** Medical records are not required with the claim, but must be available upon CareSource's request. Clinical information documented in the patient's records must support to use of this modifier.

**X. Modifier 66 - Surgical Team**

- A. Modifier 66 is reported when three or more surgeons work together during a highly complex procedure are carried out under the "surgical team" concept. Such circumstances may be identified by each participating individual with the addition of modifier 66 to the basic procedure code used for reporting services.
- B. Claims submitted by team surgeons are identified with modifier 66.
- C. The Centers for Medicare & Medicaid Services (CMS) established a Team Surgery Indicator (TEAM SURG) found in the CMS National Physician Fee Schedule Relative Value File. Values are:
  - 1. 0 - Team surgeons not permitted for this procedure.
  - 2. 1 - Team surgeons may be paid; supporting documentation is required to establish medical necessity.
  - 3. 2 - Team surgeons permitted.
  - 4. 9 - Team surgeon concept does not apply.
- D. Codes with CMS Team Surgery Indicators of 0 and 9 should not be billed with modifier 66.
- E. Modifier 66 should not be used if a surgeon acts as an assistant surgeon on a separate procedure not included in the team surgery.



Effective Date: 09/01/2019

- F. Only one surgeon may be considered the primary surgeon. CareSource will not reimburse procedures when two surgeons each bill one side of bilateral surgery as the primary surgeon.
- G. Each physician participating in the surgical team must bill the applicable procedure code(s) for their individual services with Modifier 66.
- H. Procedure code with modifier 66 appended will reimburse at 150% of the established fee, divided equally between the team surgeons.
- I. For team surgery with three surgeons, each surgeon will be reimbursed at 50% of the fee schedule amount.

**Note:** Medical records are not required with the claim, but must be available upon CareSource's request. Clinical information documented in the patient's records must support to use of this modifier.

**XI. Modifier 73 - Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia**

- A. Modifier 73 is reported to a service to indicate that due to extenuating circumstances or those that threaten the well-being of the patient, a surgical or diagnostic procedure at an outpatient hospital or ambulatory surgical center (ASC) was discontinued **prior** to the administration of anesthesia.
- B. Modifier 73 is only appropriate for use by an ASC.
- C. Modifier 53 should **not** be used for any ASC service as the modifier is used exclusively on a professional claim.
- D. Procedure code with Modifier 73 appended will reimburse at 50% of the ASC's fee schedule amount.

**Note:** Medical records are not required with the claim, but must be available upon CareSource's request. Clinical information documented in the patient's records must support to use of this modifier.

**XII. Modifier 74 - Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia**

- A. Modifier 74 is reported when due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure **after** the administration of anesthesia or after the procedure was started (incision made, intubation started, scope inserted.)
- B. Modifier 74 is not appropriate for the elective cancellation or postponement of a procedure based on the physician or patient's choice.
- C. Modifier 74 is not appropriate when the termination of the procedure occurs **prior** to the beginning of the procedure or the administration of anesthesia.
- D. Modifier 74 is not for physician use. It is only appropriate for the ASC.
- E. Procedure code with modifier 74 appended will be reimbursed at 100% of the fee schedule amount.

**Note:** Medical records are not required with the claim, but must be available upon CareSource's request. Clinical information documented in the patient's records must support to use of this modifier.

**XIII. Modifier 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**

- A. Modifier 78 is reported to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure).



1. When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure.
2. Modifier 78 should be appended when:
  - i. The return to the operating room is unplanned.
  - ii. The service is performed by same physician who performed the initial procedure.
  - iii. The service is related to the initial procedure.
  - iv. The service is performed during the postoperative period of the initial procedure (10-90 days)
- B. Procedure code with modifier 78 appended will be reimbursed at 70% of the fee schedule amount.

**Note:** Medical records are not required with the claim, but must be available upon CareSource's request. Clinical information documented in the patient's records must support to use of this modifier.

#### **XIV. Modifier 80 - Assistant Surgeon**

- A. Modifier 80 is reported to indicate surgical assistant services by a physician and is applied to the surgical procedure code(s).
- B. Assistant Surgeon provides full assistance to the primary surgeon and is capable of taking over the surgery should the primary surgeon become incapacitated.
- C. Modifier 80 will not be accepted from non-physicians. Modifier AS should be used.
- D. Procedure code with modifier 80 appended will be reimbursed at 16% of the fee schedule amount.

**Note:** Medical records are not required with the claim, but must be available upon CareSource's request. Clinical information documented in the patient's records must support to use of this modifier and operative notes must contain sufficient information to support the medical necessity of an assistant at surgery. If there is no accounting by the surgeon for what was performed by the assistant the claim would be denied.

#### **XV. Modifier 81 - Minimum Assistant Surgeon**

- A. Modifier 81 is reported to indicate minimum surgical assistant services and is applied to the surgical procedure code(s).
- B. Minimum Assistant Surgeon is an assistant who does not participate in the entire procedure but provides minimal assistance to the primary surgeon.
- C. Modifier 81 will not be accepted from non-physicians. Modifier AS should be used.
- D. Procedure code with modifier 81 appended will be reimbursed at 16% of the fee schedule amount.

**Note:** Medical records are not required with the claim, but must be available upon CareSource's request. Clinical information documented in the patient's records must support to use of this modifier and operative notes must contain sufficient information to support the medical necessity of an assistant at surgery. If there is no accounting by the surgeon for what was performed by the assistant the claim would be denied.

#### **XVI. Modifier 82 - Assistant Surgeon (when qualified resident surgeon not available)**

- A. Modifier 82 is reported to indicate when surgical assistance is needed, but a qualified resident was not available.
- B. Modifier 82 is used primarily in teaching hospitals to indicate that a qualified resident surgeon is unavailable.



- C. The unavailability of a qualified resident surgeon is a prerequisite for the use of this modifier. The assistant must provide documentation (certification) stating that a qualified resident was not available for this procedure and why the resident was not available.
- D. Procedure code with modifier 82 appended will be reimbursed at 16% of the fee schedule amount.

**Note:** Medical records are not required with the claim, but must be available upon CareSource's request. Clinical information documented in the patient's records must support the use of this modifier and operative notes must contain sufficient information to support the medical necessity of an assistant at surgery and why a qualified resident was not available. If there is no accounting by the surgeon for what was performed by the assistant the claim would be denied.

**XVII. Modifier AA** - Anesthesia services performed personally by an anesthesiologist

- A. Modifier AA is used to report when the anesthesia services are personally performed by an Anesthesiologist.
- B. Procedure code with modifier AA appended will be reimbursed at 100% of the fee schedule amount.

**XVIII. Modifier AD** - Anesthesia services supervised by an anesthesiologist: more than 4 concurrent anesthesia procedures.

- A. Modifier AD is used to report when the anesthesia services are supervised by an anesthesiologist: more than 4 concurrent anesthesia procedures.
- B. Procedure code with modifier AD appended will be reimbursed at 100% of the fee schedule amount.

**XIX. Modifier QK** - Medical direction of 2, 3 or 4 concurrent anesthesia services involving qualified individuals.

- A. Modifier QK is used to report when medical direction of 2, 3 or 4 concurrent anesthesia services involving qualified individuals.
- B. Procedure code with modifier QK appended will be reimbursed at 50% of the fee schedule amount.

**XX. Modifier QX** - Anesthesia services performed by a CRNA with medical direction by an anesthesiologist.

- A. Modifier QX is used to report when the anesthesia services are performed by a CRNA with medical direction by an anesthesiologist.
- B. Procedure code with modifier QX appended will be reimbursed at 50% of the fee schedule amount.

**XXI. Modifier QY** - Anesthesia services when an Anesthesiologist medically directs one CRNA.

- A. Modifier QY is used to report when an Anesthesiologist medically directs one CRNA.
- B. Procedure code with modifier QY appended will be reimbursed at 50% of the fee schedule amount.

**XXII. Modifier QZ** - Anesthesia services performed personally by a CRNA without medical direction by a physician.

- A. Modifier QZ is used to report when the anesthesia services are personally performed by a CRNA.
- B. Procedure code with modifier QZ appended will be reimbursed at 100% of the fee schedule amount.

**XXIII. Modifier AE** - Registered dietician

- A. Modifier AE is reported to indicate when a registered dietician provides the service.



- B. Procedure code with modifier AE appended will be reimbursed at 85% of the fee schedule amount.

**XXIV. Modifier AS** - Physician Assistant (PA), Nurse Practitioner (NP) or Certified Nurse Specialist (CNS) served as the assistant at surgery.

- A. Modifier AS must only be used if the PA, NP or CNS was acting as a surgical assistant in place of another surgeon.
- B. Procedure code with modifier AS appended will be reimbursed at 16% of the base code allowable fee schedule before multiple surgery reductions are taken.

**Note:** Medical records are not required with the claim, but must be available upon CareSource's request. Clinical information documented in the patient's records must support the use of this modifier and operative notes must contain sufficient information to support the medical necessity of an assistant at surgery. If there is no accounting by the surgeon for what was performed by the assistant the claim would be denied.

**XXV. Modifier JW** - Drug amount discarded (wasted)/not administered to any patient

- A. CareSource will consider reimbursement for:
  - 1. A single-dose or single-use vial drug that is wasted, when Modifier JW is appended.
  - 2. The wasted amount when billed with the amount of the drug that was administered to the member.
  - 3. The wasted amount billed that is not administered to another patient.
- B. CareSource will NOT consider reimbursement for:
  - 1. The wasted amount of a multi-dose vial drug.
  - 2. Any drug wasted that is billed when none of the drug was administered to the patient.
  - 3. Any drug wasted that is billed without using the most appropriate size vial, or combination of vials, to deliver the administered dose.

**XXVI. Modifier SA** - Nurse practitioner (NP) rendering service in collaboration with a physician

- A. Modifier SA is reported to indicate when a supervising physician is billing on behalf of an ANP, or CRNFA for non-surgical services.
- B. Modifier SA is used when the ANP, or CRNFA is assisting with any other procedure that DOES NOT include surgery.
- C. Procedure code with modifier SA appended will be reimbursed at 85% of the fee schedule amount.

**XXVII. Modifier TC** - Technical Component

- A. Technical component charges are institutional charges and not billed separately by physicians.
- B. A charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding Modifier TC to the usual procedure code.

**XXVIII. Modifier 26** - Professional Component

- A. Certain procedures are a combination of a physician component and a technical component.
- B. When the physician component is reported separately, the service may be identified by adding the modifier 26 to the usual procedure number.



## E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting Centers for Medicare and Medicaid Services (CMS) approved CPT/HCPCS codes along with appropriate modifiers, if applicable. Please refer to the CMS fee schedule for appropriate codes.

Providers must follow proper billing, industry standards, and state compliant codes on all claim submissions. The use of modifiers must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

**Note:** In the event of any conflict between this policy and a provider's contract with CareSource, the provider's contract will be the governing document.

## F. Related Policies/Rules

N/A

## G. Review/Revision History

DATE		ACTION
Date Issued	09/01/2019	New policy
Date Revised		
Date Effective	09/01/2019	
Date Archived	03/31/2022	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCL guidelines without a formal documented Policy

## H. References

1. Billing 340B Modifiers under the Hospital Outpatient Prospective Payment System (OPPS). (2018, April 2). Retrieved 3/22/2019 from <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Billing-340B-Modifiers-under-Hospital-OPPS.pdf>.
2. CPT® overview and code approval. (2019, March 22). Retrieved from <https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval>.
3. Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners. (2018, November 30). Retrieved February 18, 2019 from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>.
4. Medicare Claims Processing Manual Chapter 14 - Ambulatory Surgical Centers. (2017, December 22). Retrieved February 18, 2019 from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf>.
5. Optum360 EncoderProForPayers.com - Login. (2019, February 18). Retrieved February 18, 2019 from [https://www.encoderproforpayers.com/encoderpro4payers/allModifiersHandler.do?\\_k=101\\*0&\\_a=listRelated&menu=4](https://www.encoderproforpayers.com/encoderpro4payers/allModifiersHandler.do?_k=101*0&_a=listRelated&menu=4).

**The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.**