Modifier Payment Policy

Policy Statement

Neighborhood accepts all standard CPT and HCPCS modifiers in accordance with the appropriate CPT or HCPCS procedure code(s). Certain modifiers, when submitted appropriately, will impact professional reimbursement. The absence of an appropriate modifier, or the use of an inappropriate modifier, may result in claim denial.

The modifiers outlined in this policy are limited to those that affect claims processing and/or reimbursement. For all non covered modifiers, please refer to Neighborhood's Non-Covered Payment Policy.

Scope

This policy applies to:

☒**Medicaid** *excluding Extended Family Planning (EFP)*

☒**INTEGRITY**

☒**Commercial**

Prerequisites

All services must be medically necessary to qualify for reimbursement. Neighborhood may use the following criteria to determine medical necessity:

- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- Industry accepted criteria such as Interqual
- Rhode Island Executive Office of Health and Human Services (EOHHS) recommendations
- Clinical Medical Policies (CMP)

It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific Prior Authorization Reference page.
- Neighborhood's Clinical Medical Policies.

Please contact Provider Services at 1-800-963-1001 for questions related to this policy.

Reimbursement Requirements

Providers are reimbursed according to Neighborhood's contracted rates. Claims are subject to claim edits that are updated regularly. Medical notes may be required on certain modifiers to determine medical necessity.

Unusual Procedure or Service, Modifier 22

If a procedure is substantially greater than typical, the provider must document the additional work and the reason for the additional work in order to bill for additional reimbursement.

The documentation guidelines include that the reason for the additional work:

- Increased intensity
- Increased time
- Increased technical difficulty
- Severity of the patient's condition
- Physical and mental effort required

Post-Surgical Visits, Modifier 24

Post-surgical visits billed by the physician that performed the surgery are considered inclusive in the surgical procedure and are not separately reimbursable. Exception:

- Post-surgical visits not related to surgery will be considered for separate reimbursement. Modifier 24 should be billed to indicate a visit outside of the global package.

Separately Identifiable Services, Modifier 25

Significant separately identifiable Evaluation and Management services that are performed by the same physician on the same day as a procedure or other service should be indicated by the addition of the modifier 25 to the Evaluation and Management code. Modifier 25 should be used with E/M codes only and not appended to the surgical procedure code(s).

Professional and Technical Components, Modifiers 26 and TC

Modifiers 26 and TC represent distinct components of a global procedure or service. When the physician's services are reported separately, the service may be identified by appending modifier 26 to the usual procedure code. When the technical component is reported separately, modifier TC should be reported with the usual procedure code.

Return to the Operating Room, Modifiers 58 and 78

Modifiers 58 and 78 are used on surgical codes to indicate procedures that are performed during the postoperative period of the initial surgery. Medical records may be required to substantiate medical necessity.

- Services that do not require a return to the operating room cannot be billed with this modifier.
- The physician must bill the procedure code that best describes the surgical procedures performed. The initial procedure code should not be billed unless the exact identical procedure is performed again.
- A new postoperative period does not begin when the procedure performed to treat the complication is performed.
- When a procedure with a 000 global period is performed to treat complications, the follow up procedure is reimbursed at 100%.
- Full payment is allowed for the treatment of complications by another physician or surgeon. These services should not be billed with a 78 modifier.

Surgical Modifiers 54, 55 and 56

Modifiers 54, 55, and 56 are used when only a part of the global surgical package is performed by the physician or provider. Failure to indicate the portion of the surgical package performed by the physician results in an overpayment and billing for services not rendered.

These modifiers should be added to procedures with a 90-day global period and not for procedures with zero or 10-day global periods.

The percentages paid for these modifiers are set by contract or Neighborhood Health Plan of RI standard modifier allowances.

If the physicians performing surgical, post or preoperative care are within the same group or a covering physician, modifiers 54, 55 and 56 should not be used.

Modifier 54 – Surgical care only indicates that the physician performed only the intra-operative portion of the surgical procedure.

- When using Modifier 54, there must be a notation in the record agreeing to the transfer of the postoperative care to another physician or provider.

Modifier 55 – Postoperative management only indicates that the physician performed only the postoperative care and management after another physician performed the surgery.

- Modifier 55 is added to the surgery code only after the initial postoperative visit is completed by the physician providing the postoperative care.
- Modifier 55 is used only after the patient has been discharged from the hospital. If another physician sees the patient after surgery, the physician (not the surgeon) will bill using the hospital care codes.

Modifier 56 – Preoperative management only indicates that the physician only provided the preoperative evaluation and management services of the global surgical package.

- Modifier 56 is used in rare instances and only on surgical codes.

Distinct Procedural Service, Modifier 59

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations. Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-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. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

CMS has established the following four HCPCS modifiers to define specific subsets of modifier 59:

- XE - Separate encounter, a service that is distinct because it occurred during a separate encounter
- XP - Separate practitioner, a service that is distinct because it was performed by a different practitioner
- XS - Separate structure, a service that is distinct because it was performed on a separate organ/structure
- XU - Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

Team and Co-Surgeons, Modifiers 62 and 66

Two surgeons or a team of surgeons may be required to perform a surgical procedure due to the complexity of the procedure or the patient's medical status. Modifiers 62 and 66 are used to indicate that two providers or a surgical team are billing for the same procedure on the same patient.

- All procedures performed by co-surgeons or a team of surgeons must have appropriate documentation to establish the medical necessity for two surgeons. In most instances, payment for an assistant surgeon is not allowed unless clear and compelling medical documentation can support the medical necessity.
- If a procedure does not call for a co-surgeon or a team of surgeon, the service will be denied.

Unrelated Services During a Post-Operative Period, Modifier 79

The physician may need to indicate that a procedure or service furnished during a post-operative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79.

Assistants at Surgery, Modifiers 80, 81, 82 and AS

An assistant at surgery is a physician who actively assists the physician in charge of the case in performing a surgical procedure. The presence of an assistant at surgery must be medically necessary and appropriate for the surgical procedure. Neighborhood Health Plan of RI currently accepts the following modifiers that were developed to report assistant surgeon services. The differences between the modifiers are important in the correct reimbursement of the provider.

Modifier 80 – is a physician who is an assistant surgeon who fully assists in the surgery.

Modifier 81 – is for minimal assistance and indicates that the surgeon did not assist for the entire surgery but for a limited amount of time..

Modifier 82 – was developed to be used only at teaching hospitals. It identifies that the teaching facility does not have a teaching program that is related to the medical specialty required by the surgical procedure or there is no qualified resident available, or the surgeon does not use residents or interns during the surgery.

Modifier AS – the assistant at the surgery was a non-physician provider such as a PA, NP, or clinical nurse specialist licensed in that state to act as an assistant at surgery. This modifier should not be billed by a physician.

There are procedures that are approved by Amercian Medical Association (AMA) for multiple assistant surgeons. In these situations, each assistant surgeon should bill with the assistant surgeon modifier. Medical notes may be required to establish medical necessity and should clearly document the assistant surgeon's role during the operative session. If a procedure does not call for an assistant(s), the service will be denied.

Repeat Clinical Diagnostic Laboratory Test, 91

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91.

Locum Tenen, Modifier Q6

Service furnished under a fee-for-time compensation arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area. Claims should be submitted under the contracted provider with a Q6 modifier indicating that the service was rendered by a substitute provider.

Modifier	Description	Percentage reimbursed (of fee schedule or allowance for procedure)
22	Unusual procedural services	120%
23	Unusual anesthesia	120%

Modifier	Description	Percentage reimbursed (of fee schedule or allowance for procedure)
25	Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service	100%
26	Professional component	30%
50	Bilateral procedure	(Refer to the Multiple Procedures Payment Policy)
51	Multiple procedures	(Refer to the Multiple Procedures Payment Policy)
52	Reduced services	15%
53	Discontinued procedure	20%
54	Surgical care only	69%
55	Postoperative care only	21%
56	Preoperative care only	10%
58	Staged or related procedure or service by the same provider during the postoperative period	69%
59, XE, XP, XS, XU	Distinct procedural service	100%
62	Two surgeons/ Co-surgeons	62%
66	Surgical team	62%
73	Discontinued outpatient hospital/Ambulatory Surgery Center (ASC) procedure prior to the administration of anesthesia	50%
78	Unplanned return to the operating room by the same provider following the initial procedure for a related procedure during the postoperative period	69%

Modifier	Description	Percentage reimbursed (of fee schedule or allowance for procedure)
79	Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period	100%
80	Assistant surgeon	20%
81	Minimum assistant surgeon	15%
82	Assistant surgeon (when qualified resident surgeon not available)	20%
91	Repeat clinical diagnostic laboratory test	100%
AS	Physician assistant; nurse practitioner	13.60%
RR	Rental	10%
Q6	Service furnished under a Locum Tenens agreement	100%
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	(Refer to Anesthesia Policy)
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist	(Refer to Anesthesia Policy)
QX	CRNA service: with medical direction by a physician	(Refer to Anesthesia Policy)
QZ	CRNA service: without medical direction by a physician	(Refer to Anesthesia Policy)
TC	Technical component	70%

Exclusions

For non-covered modifiers please refer to the Non-Covered Services Payment Policy.

Claim Submission

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of

Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

Documentation Requirements

Neighborhood reserves the right to request medical records for any service billed. Documentation in the medical record must support the service(s) billed as well as the medical necessity of the service(s). Neighborhood follows CMS standards for proper documentation requirements.

Member Responsibility

Commercial plans include cost sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost sharing obligations or contact Member Services prior to finalizing member charges.

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Document History

Date	Action
09/05/23	Policy Review. Update to include Anesthesia and Locum Tenen modifiers. Updated policy statement to reflect professional claims. Updated assistant surgeon documentation requirements.
05/16/22	Policy Created. Documentation of current and active reimbursement guidance for specified modfiers.