	Reimbursement Policy	
Subject: Modifier Usage		
Effective Date: **10/03/18**	Committee Approval Obtained: **10/03/18**	Section: **Coding**

*****The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to https://providers.amerigroup.com/TX.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) benefits. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to 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.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup STAR+PLUS MMP may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup STAR+PLUS MMP reimbursement policies for Amerigroup STAR+PLUS MMP are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup STAR+PLUS MMP strives to minimize these variations.

Amerigroup STAR+PLUS MMP reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup STAR+PLUS MMP allows reimbursement for covered services provided to eligible members when billed with appropriate procedure codes and appropriate modifiers when applicable unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement is based on the code-set combinations submitted with the correct modifiers. The use of certain modifiers requires the provider to

	submit supporting documentation along with the claim. Refer to the specific modifier policies for guidance on documentation submission. Amerigroup STAR+PLUS MMP reserves the right to review adherence to correct coding for high-volume modifiers. Applicable electronic or paper claims billed without the correct modifier in the correct format may be rejected or denied. The modifier must be in capital letters if alpha or alphanumeric. Rejected or denied claims must be resubmitted with the correct modifier in conjunction with the code-set to be considered for reimbursement. Corrected and resubmitted claims are subject to timely filing guidelines. The use of correct modifiers does not guarantee reimbursement. **Reimbursement Modifiers** Reimbursement modifiers (Exhibit A) affect payment and denote circumstances when an increase or reduction is appropriate for the service provided. The modifiers must be billed in the primary or first modifier field locator. **Informational Modifiers Impacting Reimbursement** Informational modifiers determine if the service provided will be reimbursed or denied. Modifiers that impact reimbursement should be billed in modifier locator fields after reimbursement modifiers if any. **Informational Modifiers Not Impacting Reimbursement** Informational modifiers are used for documentation purposes. Modifiers that do not impact reimbursement should be billed in the subsequent modifier field locators. Amerigroup STAR+PLUS MMP reserves the right to reorder modifiers to reimburse correctly for services provided. In the absence of state-specific modifier guidance, Amerigroup STAR+PLUS MMP will default to CMS guidelines.
History	• Biennial review approved and effective **10/03/18**: Review adherence to correct coding policy language added; Exhibit A Modifier FX updated • Update due to regulatory directive*:* Effective **01/01/18**, Exhibit A updated — Modifier FY added • Review approved **08/31/17**: Exhibit A Modifier QF updated • Update due to regulatory directive: Exhibit A updated — Modifier QF added, effective **07/19/17** • Initial approval **04/03/17** and effective **10/01/17**
References and Research Materials	This policy has been developed through consideration of the following: • CMS policies • Texas Health and Human Services Commission (HHSC)

	• Amerigroup STAR+PLUS MMP contract with HHSC
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Assistant at Surgery (80/81/82/AS) • Claims Timely Filing • Consultations • Distinct Procedural Services (Modifiers 59, XE, XP, XS, XU) • Documentation Standards for Episodes of Care • Duplicate or Subsequent Services on the Same Date of Service • Early and Periodic Screening, Diagnostic and Treatment • Modifier 22: Increased Procedural Service • Modifier 24: Unrelated Evaluation and Management Service by Same Physician During Postoperative Period • Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by Same Physician on Same Day of Procedure or Other Service • Modifier 57: Decision for Surgery • Modifier 62: Cosurgeons • Modifier 63: Procedure on Infants Less than 4 kg • Modifier 66: Surgical Teams • Modifier 76: Repeat Procedure by Same Physician • Modifier 77: Repeat Procedure by Another Physician • Modifier 78: Unplanned Return to Operating/Procedure Room by Same Physician Following Initial Procedure for a Related Procedure During Postoperative Period • Modifier 91: Repeat Laboratory Test • Modifier LT and RT: Left Side/Right Side Procedures • Multiple and Bilateral Surgery: Professional and Facility Reimbursement • Multiple Delivery Services • Physician Standby Services • Portable/Mobile/Handheld Radiology Services • Preadmission Services for Inpatient Stays • Preventive Medicine and Sick Visits on the Same Day • Professional Anesthesia Services • Reimbursement for Reduced or Discontinued Services • Robotic Assisted Surgery • Split-Care Surgical Modifiers • Transportation Services • Vaccines for Children
Related Materials	• None

Exhibit A: Reimbursement Modifiers Listing[1]

Modifier	Description
22	Increased procedural service
24	Unrelated evaluation and management service by same physician during postoperative period
25	Significant, separately identifiable evaluation and management service by same physician on same day of procedure or other service (also for facility use)
26	Professional component
50	Bilateral procedure (also for facility use)
51	Multiple procedure
52	Reduced service (also for facility use)
53	Discontinued service
54	Surgical care only
55	Postoperative care only
56	Preoperative care only
57	Decision for surgery
59/XE/XP/XS/XU	Distinct procedural service (also for facility use)
62	Co-surgeons
63	Procedure performed on infants less than 4 kg
66	Surgical teams
73	Discontinued outpatient hospital/ambulatory surgery center procedure prior to administration of anesthesia (for facility use only)
74	Discontinued outpatient hospital/ambulatory surgery center procedure after administration of anesthesia (for facility use only)
76	Repeat procedure by the same physician (also for facility use)
77	Repeat procedure by another physician (also for facility use)
78	Unplanned return to operating/procedure room by same physician following initial procedure for a related procedure during postoperative period (also for facility use)
80	Assistant at surgery
81	Minimal assistant at surgery
82	Assistant at surgery (when a qualified resident surgeon is not available)
91	Repeat laboratory test (also for facility use)
99	Multiple modifiers (also for facility use)
AA	Anesthesiology service performed personally by an anesthesiologist

[1] The above list does not include market-specific modifiers; all modifiers are for use by professional providers only unless otherwise indicated in modifier description.

AD	Medical supervision by a physician; more than four concurrent anesthesia procedures
AG	Primary physician
AH	Clinical psychologist
AJ	Clinical social worker
AQ[2]	Physician providing a service in a health professional shortage area (for use by Medicare nonparticipating physicians only)
AS	Physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) services for assistant at surgery
CT	Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association XR-29-2013 standard
D/E/G/H/I/J/N/P/R/S/X	Transportation origin and destination
FC	Partial credit received on replaced device
FX	X-ray taken using film
FY[2]	Computed radiography services furnished
GF	Physician services provided by a nonphysician in a critical access hospital; nonphysician: NP, certified registered nurse anesthetist (CRNA), certified registered nurse, CNS, PA
GM	Multiple transports
GT	Telemedicine via interactive audio and video telecommunications systems
HM	Less than bachelor's degree level
HN	Bachelor's degree level
HO	Master's degree level
HP	Doctoral level
HQ	Group setting (for behavioral health use)
HT	Multidisciplinary team (for behavioral health use)
KR	Rental item, durable medical equipment — billing for partial month
NU	New equipment
P1/P2/P3/P4/P5/P6	Anesthesia physical status
QF	Prescribed amount of oxygen exceeds four liters per minute and portable oxygen is prescribed
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
QL	Member pronounced dead after ambulance called but before loaded onboard ambulance
QX	CRNA service with medical direction by a physician
QY	Anesthesiologist medically directs one CRNA
QZ	CRNA service without medical direction by a physician

[2] Medicare-only modifier

RR	Rental equipment
SA	NP rendering service in collaboration with a physician
SB	NP (for use by midwives only)
SH	Second concurrently administered infusion therapy
SJ	Third or more concurrently administered infusion therapy
TC	Technical component
TD	Registered nurse (for behavioral health, physical health and home health use)
TE	Licensed practical nurse (for behavioral health, physical health and home health use)
TK	Extra member or passenger nonambulance transportation
UE	Used equipment
UN	Portable/mobile radiology transport — two members served
UP	Portable/mobile radiology transport — three members served
UQ	Portable/mobile radiology transport — four members served
UR	Portable/mobile radiology transport — five members served
US	Portable/mobile radiology transport — six or more members served