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| | | Reimbursement Policy |
| Subject: Modifier Usage | | |
| Effective Date: 10/08/20 | Committee Approval Obtained: 10/08/20 | Section: Coding |
| <p>*****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.*****</p> | | |
| <p>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.</p> <p>If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup STAR+PLUS MMP may:</p> <ul style="list-style-type: none"> • Reject or deny the claim. • Recover and/or recoup claim payment. <p>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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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.</p> <p>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.</p> | | |
| Policy | <p>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.</p> <p>Reimbursement is based on the code-set combinations submitted with the correct modifiers. The use of certain modifiers requires the provider to</p> | |

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| | <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>In the absence of state-specific modifier guidance, Amerigroup STAR+PLUS MMP will default to CMS guidelines.</p> |
| <p>History</p> | <ul style="list-style-type: none"> • Biennial Review approval and effective 10/08/20: Updated References and Research Materials, Related Policies, Exhibit A Modifiers 58, 90, FB, GN, GO, GP • Update due to regulatory directive, effective 01/01/20, Exhibit A updated – Modifiers CO and CQ added • 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 |

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| | <ul style="list-style-type: none"> Initial approval 04/03/17 and effective 10/01/17 |
| References and Research Materials | <p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> Amerigroup STAR+PLUS MMP contract with HHSC American Medical Association (AMA), CPT 2020, Professional Edition American Medical Association (AMA), HCPCS 2020, Expert Edition CMS Optum 360 Encoder Pro for Payers Professional Texas Health and Human Services Commission (HHSC) |
| Definitions | <ul style="list-style-type: none"> General Reimbursement Policy Definitions |
| Related Policies | <ul style="list-style-type: none"> 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 90: Reference (Outside) Laboratory and Pass-Through Billing 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 |

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| | <ul style="list-style-type: none"> • Split-Care Surgical Modifiers • Transportation Services • Vaccines for Children |
| Related Materials | <ul style="list-style-type: none"> • None |

Exhibit A: Reimbursement Modifiers Listing¹

| Modifier | Description |
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| 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 |
| 58 | Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period |
| 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 |

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.

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| 81 | Minimal assistant at surgery |
| 82 | Assistant at surgery (when a qualified resident surgeon is not available) |
| 90 | Reference (Outside) Laboratory (also for facility use) |
| 91 | Repeat laboratory test (also for facility use) |
| 99 | Multiple modifiers (also for facility use) |
| AA | Anesthesiology service performed personally by an anesthesiologist |
| 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 |
| CO ³ | Outpatient occupational therapy services furnished in whole or in part by an occupational therapist assistant |
| CQ ³ | Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant |
| 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 |
| FB | Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples) |
| 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 |
| GN | Services delivered under an outpatient speech language pathology plan of care |
| GO | Services delivered under an outpatient occupational therapy plan of care |
| GP | Services delivered under an outpatient physical therapy plan of care |
| GT | Telemedicine via interactive audio and video telecommunications systems |

² Medicare-only modifier

³ Modifier is applicable to Medicare Advantage and MMP markets only

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| 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 |
| 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 |