

Reimbursement Policy	
Subject: Modifier Usage	
Policy Number: G-06006	Policy Section: Coding
Last Approval Date: 02/09/2022	Effective Date: 02/09/2022

**** 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://provider.amerigroup.com>. ****

Disclaimer

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 Medicare Advantage benefit plan. 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 participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup Medicare Advantage may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Amerigroup Medicare Advantage reimbursement policies 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 Medicare Advantage strives to minimize these variations.

Amerigroup Medicare Advantage 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 our provider website.

Policy

Amerigroup Medicare Advantage 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 Medicare Advantage 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 Medicare Advantage reserves the right to reorder modifiers to reimburse correctly for services provided.

Related Coding

Description	Comment
Reimbursement Modifiers	Reimbursement Modifiers In the absence of a modifier specific reimbursement policy, providers should refer to their provider manual and state and federal guidelines for guidance on modifiers affecting reimbursement or modifiers reimbursed specific to state and federal payment methodologies.

Policy History

02/09/2022	Policy review and effective: updated policy template, added Reimbursement Modifiers Listing — Code List as separate
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	document; updated Related Coding section with a Note: In the absence of a modifier specific reimbursement policy, providers should refer to their provider manual, and state and federal guidelines for guidance on modifiers affecting reimbursement or modifiers reimbursed specific to state and federal payment methodology; expanded Modifier FB to Facility providers; added Modifier CO & CQ for Medicare Advantage/MMP only
10/08/2020	Review approval and effective: Updated References and Research Materials, Related Policies, Modifiers 58, 90, FB, GN, GO, GP
01/01/2020	Update due to regulatory directive: Modifiers CO and CQ added
10/03/2018	review approved and effective: review adherence to correct coding policy language added; Modifier FX updated
01/01/2018	Update due to regulatory directive: effective; Modifier FY added
08/31/2017	Review approved: Modifier QF updated
07/19/2017	Update due to regulatory directive: Modifier QF added
04/03/2017	Review approved and effective 09/15/2017: Modifier FX added; policy template updated
08/01/2016	Review approved and effective; Modifier CT added
01/01/2015	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract
- Optum Encoder Pro for Payers Professional

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

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 (EPSDT)

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 26 and TC: Professional and Technical Component
Modifier 57: Decision for Surgery
Modifier 62: Co-Surgeons
Modifier 63: Procedure on Infants Less Than 4kg
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
Split Care Surgical Modifiers
Transportation Services
Vaccines for Children