POLICY NUMBER: 80

POLICY TITLE: Modifier Payment Policy

POLICY STATEMENT: Medical Associates Health Plan accepts all standard CPT and HCPCS modifiers submitted in accordance with the appropriate CPT or HCPCS procedure code(s). Certain modifiers when submitted may impact reimbursement.

Billing Information
Reference the most updated industry standard coding guidelines for a complete list of modifiers. In the instances when a modifier is submitted incorrectly with the procedure code, Medical Associates Health Plan will deny the claim line for incorrect use of modifier.

EDI Claim Submitter Information
- Submit the appropriate modifier(s) with the corresponding CPT or HCPCS procedure codes in HIPAA compliant 837P format for professional services or 837I format for institutional services.
- Claims submitted with non-standard modifiers will be rejected if submitted electronically.

Paper Claim Submitter Information
- Submit the appropriate modifier(s) after the corresponding CPT or HCPCS procedure codes on a CMS-1500 form for professional service in Box 24d Procedures, Services, or Supplies field.

Reimbursement
Claims are subject to payment edits that are updated at regular intervals and generally based on CMS, Specialty Society Guidelines and National Correct Coding Initiative (CCI).

Multiple Modifiers
Medical Associates Health Plan recognizes all industry standard modifiers, the modifiers that may impact claims reimbursement are as follows in Table A. All other industry standard CPT and HCPCS modifiers are accepted by Medical Associates Health Plan, but are not utilized for claims processing purposes and have no impact on how the claim is paid.

Medical Associates Health Plan accepts multiple modifiers submitted; modifiers will be processed according to the priority assigned by Medical Associates Health Plan. The priority of the modifiers can be found in Table A below. The modifiers are processed in priority order starting at the lowest priority first.

Table A:
Modifiers contained in this table may have an impact to claim reimbursement. References to fee schedule reimbursement are illustrative and not a guarantee of payment.

Modifier	Description	Reimbursement Impact	Priority
22	Unusual Services	125% of the contracted fee schedule/contracted amount	11
26	Professional Component	100% of the contracted fee schedule/contracted amount (not Global Fee)	02
50	Bilateral	150% of the contracted fee schedule/contracted amount	14
51	Multiple Procedures	50% of the contracted fee schedule/contracted amount	15
52	Reduced Services	50% of the contracted fee schedule/contracted amount	50
53	Discontinued procedure ASC or Outpatient before administration of anesthesia	50% of the contracted fee schedule/contracted amount	51
54	Surgical Services Performed by one MD when another MD did the PreOP/PostOP	80% of the contracted fee schedule/contracted amount	52
55	Postoperative Management when another MD performed the surgery	20% of the contracted fee schedule/contracted amount	53
56	Preoperative Management when surgery to be performed by another MD	10% of the contracted fee schedule/contracted amount	54
62	Two Surgeons providing services in a surgical procedure	62.5% of the contracted fee schedule/contracted amount	55
63	Procedure Performed on infants	120% of the contracted fee schedule/contracted amount	56
66	Surgical Team	62.5% of the contracted fee schedule/contracted amount	60
73	Discontinued procedure ASC or Outpatient before administration of anesthesia	50% of the contracted fee schedule/contracted amount	57
78	Return to operating room for related procedure	70% of the contracted fee schedule/contracted amount	45
80	Assistant Surgeon	16% of the contracted fee schedule/contracted amount	35
81	Minimum Assistant Surgeon	16% of the contracted fee schedule/contracted amount	36
82	Assistant Surgeon when qualified Resident is not available	20% of the contracted fee schedule/contracted amount	37

Modifier	Description	Reimbursement Impact	Priority
AS	Physician Assistant	13.6% of the contracted fee schedule/contracted amount	38
CO	Outpatient Services by an OT assistant	85% of the contracted fee schedule/contracted amount	95
CQ	Outpatient Physical therapy services by a PT Assistant	85% of the contracted fee schedule/contracted amount	96
CT	CT Service Furnished using equipment not meeting NEMA XR-29 standard	85% of the contracted fee schedule/contracted amount	10
FX	Xray taken using film	80% of the contracted fee schedule/contracted amount	98
FY	Computed Radiography Services	90% of the contracted fee schedule/contracted amount	96
KE	Bid under Round one of the DMEPOS Competitive big w/Non competitive base	116.02% of the contracted fee schedule/contracted amount	03
KH	DMEPOS item, initial claim, purchase or first month rental	100% of the contracted fee schedule/contracted amount	65
KI	DMEPOS item, second or third month rental	100% of the contracted fee schedule/contracted amount	76
KJ	DMEPOS Item parental enteral pump or capped rental, months four to fifteen	75% of the contracted fee schedule/contracted amount	74
KL	DMEPOS item delivered via mail	86% of the contracted fee schedule/contracted amount	05
QB	Amounts of Oxygen for day at rest vs night use differ and average exceeding 4	110% of the contracted fee schedule/contracted amount	99
QK	Medical direction of 2, 3 or 4 CC anesthesia procedures w/qualified individual	50% of the contracted fee schedule/contracted amount	30
QX	CRNA with medical direction by a physician	50% of the contracted fee schedule/contracted amount	65
QY	Anesthesiologist medically directs 1 CRNA	50% of the contracted fee schedule/contracted amount	33
TC	Technical Component	100% of the contracted fee schedule/contracted amount (not Global fee)	02

Original Effective Date: 06/2023;

Reviewed 06/2024