PROVIDER REIMBURSEMENT GUIDANCE			
Modifier Policy			
Original Date Approved	**Effective Date SCO/ICO**	**Effective Date MAPD***	**Revision Date**
02/10/2022	04/01/2022	04/01/2022	02/01/2022

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options (MA)
☒ One Care (MA)
☒ CCA Medicare Preferred – (PPO) MA*
☒ CCA Medicare Value - (PPO) MA*
☒ CCA Medicare Preferred – (PPO) RI*
☒ CCA Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

PAYMENT POLICY SUMMARY:

This policy addresses the appropriate use of modifiers with individual CPT and HCPCS (Healthcare Common Procedure Coding System) procedure codes.

The American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) define the use of a modifier as a means to report or indicate an alteration in a service or procedure that has been performed. The service or procedure has not changed in its definition or code but has been modified by a specific circumstance. It may also provide more information about a service such as if it were performed more than once, if unusual events occurred, or if it was performed by more than one physician and/or in more than one location.

REIMBURSEMENT REQUIREMENTS:

Per Medicare guidelines, the modifier that affects payment must be submitted first. Reimbursements will be paid only if all Plan procedures and referral requirements are followed. The presence or absence of a modifier may affect claims payment or result in a claim denial.

BILLING AND CODING GUIDELINES:

In accordance with correct coding, CCA will consider reimbursement for a procedure code/modifier combination only when the modifier has been used appropriately. Additionally, any procedure code reported with an appropriate modifier may also be subject to other CCA reimbursement policies.

Below are examples of modifiers that differ from the American Medical Association CPT guidelines.

Modifier 25 (Significant, Separately Identifiable E&M Service)

Modifier 25 is used when "the physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided or beyond the usual pre- and postoperative care associated with the procedure that was performed."

Modifier 59 (including Subsets XE, XP, XS, XU)

Modifier 59 is used to distinguish procedural services that are not usually reported together but are appropriate under certain situations. CMS established modifiers XE, XP, XS and XU to define subsets of modifier 59 and to provide greater reporting specificity in situations where modifier 59 was previously reported and may be used in lieu of modifier 59 whenever possible.

CCA will consider compensation for a claim billed with modifier 59 when the distinct procedure meets criteria including but not limited to:

- Different session or patient encounter, procedure, or anatomical site/organ system
- Separate incision/excision, lesion, or injury (or area of injury in extensive injuries)

For more detailed information, reference CCA's Modifier 59 payment policy.

Assistant at Surgery (Assistant Surgeon)

Modifiers 80, 81, 82 and AS are used to identify an assistant at surgery. An assistant at surgery is defined as a physician or other qualified healthcare professional who actively assists an operating surgeon in the execution of a surgical procedure. Both physicians are normally necessary because of the complex nature of the procedure or the patient's condition. The assistant surgeon performs medical functions under the direct supervision of the operating surgeon and is usually in the same specialty as the operating surgeon. Refer to CCA's Assistant at Surgery payment policy for more detailed guidelines.

Therapy Services Requiring a Modifier

CCA will require one of the three therapy modifiers − GN, GO, or GP on specific sets of CPT/HCPCS codes to identify when each outpatient therapy (OPT) service is furnished under a Speech language pathology (SLP), occupational therapy (OT) and physical therapy (PT) services plan of care.

CCA will reject claims that do not contain one of the designated modifiers assigned by CMS. Each code designated as "always therapy" must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them and must always be accompanied by one of the therapy modifiers.

In addition, several "always therapy" codes have been identified as discipline specific – requiring the GN modifier, the GO modifier, or the GP modifier where applicable.

CMS has established two modifiers, CQ and CO, for services furnished in whole or in part by physical therapist assistants (PTAs) and occupational therapy assistants (OTAs). Effective for claims with dates of service on and after January 1, 2020, the CQ and CO modifiers are required to be used, when

applicable, for services furnished in whole or in part by PTAs and OTAs on the claim line of the service alongside the respective GP or GO therapy modifier, to identify those PTA and OTA services furnished under a PT or OT plan of care.

The specific sets of CPT/HCPCS codes can be found at the CMS Annual Therapy Update website.

Radiology Reduction Modifiers

CCA will apply reductions to the technical component (TC) payment and the TC portion of the global fee of radiological services when appended with the CT, FX or FY modifiers as follows:

- Modifier CT
  - CAT scans furnished on non-NEMA Standard XR-29-2013-compliant equipment
  - Payment reduction of 15% will be applied to the TC payment portion
- Modifier FX:
  - Imaging services that are X-rays taken using film
  - Payment reduction of 20% will be applied to the TC payment portion
- Modifier FY:
  - Imaging services that involve cassette-based imaging which utilizes an imaging plate to create the image
  - Payment reduction of 7% will be applied to the TC payment portion

Transportation Component HCPCS Code R0075

CCA will deny procedure code R0075 (transportation of portable X-ray equipment and personnel to home or nursing care) when billed without the applicable modifier consistent with the CMS requirement that modifiers (UN, UP, UQ, UR, US) are required to be reported with HCPCS code R0075 when billing Medicare carriers for portable x-rays. These five modifiers are used to report the number of patients served during a single trip that the portable x -ray supplier makes to a specific location.

DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies, procedures, and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES:

CMS Website

CMS Annual Therapy Update

Commonwealth Care Alliance

American Medical Association (AMA) Current Procedural Terminology (CPT®)

Medicare Claims Processing Manual Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT

Services Medicare Claims Processing Manual Chapter 13 - Radiology Services and Other Diagnostic Procedures

Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services

Payment Policies:
Massachusetts / Rhode Island

Provider Manuals:
Massachusetts / Rhode Island

Prior Authorization Forms:
Massachusetts / Rhode Island