# Modifier Payment Policy

Applies to the following Tufts Health Plan products:

- ☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]
- ☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

Applies to the following Tufts Health Public Plans products:

- ☒ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- ☒ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

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In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

**Note:** Audit and disclaimer information is located at the end of this document.

## POLICY

Modifiers provide a means to report or indicate a service or procedure that can be altered by a specific circumstance without changing the procedure code. Modifiers are used to increase accuracy in compensation, coding consistency, editing and to capture payment data.

Tufts Health Plan follows AMA CPT/HCPCS coding guidelines and accepts all standard AMA CPT/HCPCS modifiers submitted in accordance with the appropriate CPT/HCPCS procedure code(s). Certain modifiers, when submitted appropriately, may impact compensation. Refer to the modifier tables for Commercial, Senior Products and Tufts Health Public Plans for a list of modifiers that directly impact claim payment, as well as commonly used modifiers that may affect claims adjudication.

Tufts Health Plan accepts the submission of multiple modifiers and recognizes industry-standard modifiers in all four modifier fields for all aspects of claims processing, including compensation. When submitting multiple modifiers, the sequence of modifiers does not impact compensation for claims. Refer to current industry standard coding guidelines for a complete list of modifiers and their usage, as well as content-specific payment policies for more information. In the instances when a modifier is submitted incorrectly with the procedure code, Tufts Health Plan will deny the claim line for incorrect use of a modifier.

**Note:** The absence or presence of the appropriate modifier does not guarantee payment.

Providers should only bill globally when they have performed both the professional and technical components in an office setting. Global services should be submitted on one claim line without appending any modifiers.

### Commercial and Senior Products

Effective for dates of service on or after February 25, 2021, Tufts Health Plan will implement changes to modifier reimbursement processing. When the modifiers listed below have been appropriately applied, as determined through the coding validation process, providers will be reimbursed at 100% of the allowed amount or fee schedule for that service, unless otherwise specified in your Tufts Health Plan contract. In cases where a modifier has been incorrectly applied, payment will be denied.

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

**Note:** This depends on the provider type, as there are provider types that could use the appropriate modifier (modifier AS) but would still have a modifier reduction applied.

| Modifier | Description |
|---|---|
| 24 | Unrelated E&M service by the same physician during a postoperative period |
| 27 | Multiple outpatient hospital evaluation and management (E/M) encounters occur for the same beneficiary on the same date of service |
| 57 | Decision for surgery |
| 58 | Staged or related procedure or service by the same physician during the postoperative period |
| 59 | Distinct procedural service |
| 78 | Unplanned return to the operating/ procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period |
| 79 | Unrelated procedure or service by the same physician during the post-operative period |
| XE | Separate encounter, a service that is distinct because it occurred during a separate encounter (this modifier should only be used to describe separate encounters on the same date of service) |
| XP | Separate practitioner, a service that is distinct because it was performed by a different practitioner |
| XS | Separate structure, a service that is distinct because it was performed on a separate organ/structure |
| XU | Unusual nonoverlapping service, the use of a service that is distinct because it does not overlap usual components of the main service |
| Anatomical Modifier (LT, RT) | Designate the area or part of the body on which the procedure is performed |

## BILLING INSTRUCTIONS

Below are examples of modifiers that differ from AMA CPT coding standards. Refer to the applicable content-specific payment policies for more information on the correct use of these modifiers.

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

AMA describes the use of modifier 25 as "the physician may need to indicate that on the day of 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."

**Commercial Products**

When an E&M code with modifier 25 and a procedure code having a 0-, 10- or 90-day postoperative period are billed by the same provider for the same date of service, Tufts Health Plan will compensate the E&M service at 50 percent of the otherwise allowed amount. This policy applies to professional and outpatient claims.

**Note:** This modifier may be appended to E&M codes 99201–99215 and 99241–99245 or to general ophthalmologic codes (92002-92014).

**Tufts Health Public Plans**

When an E&M code with modifier 25 and a procedure code having a 0-, 10- or 90-day post-operative period are billed by the same provider for the same date of service, Tufts Health Plan compensates the E&M service at 50 percent of the otherwise allowed amount. The modifier may be appended to E&M codes 99211-99215 and 99241-99245 or to general ophthalmologic codes (92012-92014). This policy only applies to professional claims.

Refer to the E&M Payment Policies for Commercial, Senior Products and Tufts Health Public Plans for more information on billing for E&M procedures.

**Modifier 59 (including Subsets XE, XP, XS, XU)**
Modifier 59 is used to identify procedural services that are not normally reported together but are appropriate under certain circumstances. 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. For more information, refer to CMS.

The compensation impact applied to modifier 59 is also applied to modifiers XE, XP, XS and XU. Refer to the modifier tables for Commercial, Senior Products and Tufts Health Public Plans for specific compensation information. All claims must be submitted with clear documentation of the appropriateness and medical necessity of the separate, distinct procedure. Payment for a distinct procedure is subject to medical necessity review.

Tufts Health Plan 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)

**Modifier KX[3]**
The KX modifier is a multipurpose, informational modifier and may be used to identify services for transgender, ambiguous genitalia, and hermaphrodite beneficiaries in addition to its other existing uses. Physicians and nonphysician practitioners should use modifier KX with procedure codes that are gender-specific in the particular cases of transgender, ambiguous genitalia and/or hermaphrodite beneficiaries.

**Note:** The KX modifier may also be used in conjunction with other medical policies including durable medical equipment for Commercial, Senior Products and Tufts Health Public Plans.

**Assistant Surgeon**
Modifiers 80, 81, 82 and AS are used to identify an assistant surgeon. An assistant surgeon is defined as a physician who actively assists an operating surgeon in the performance of a surgical procedure. Both physicians are usually 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 generally in the same specialty as the operating surgeon. Refer to the CPT-4 manual for appropriate use of modifiers and to determine what procedures warrant an assistant surgeon.

## COMPENSATION/REIMBURSEMENT INFORMATION

Tufts Health Plan does not routinely compensate for diagnostic tests and radiology services having a professional component performed in a home, assisted living facility, nursing facility or skilled nursing facility if billed without modifier 26 to indicate the professional component and transportation of portable x-ray equipment (R0070-R0075) is not also submitted.

**Note:** Tufts Health Plan does not compensate for procedure codes with a PC/TC Indicator of 9, since the concept of PC/TC does not apply.

**All Products**
**Anatomical Modifiers**
Effective for dates of service on or after April 1, 2021, Tufts Health Plan will not routinely compensate a procedure defined as requiring an anatomical modifier when billed without an associated anatomical modifier.

**Senior Products and Tufts Health Public Plans**
**Reduced/Discontinued Services Between Professional and Facility Providers**
Tufts Health Plan does not routinely compensate a service reported by a professional provider when billed without modifiers 52 or 53 if the same code is billed for the same date of service by an outpatient facility with modifiers 73 or 74.

**Tufts Health Public Plans Only**
**Discontinued Service Modifier in the Outpatient Setting**
Tufts Health Plan does not routinely compensate any service billed with modifier 53 (discontinued service) when billed with places of service 19 (outpatient hospital-off campus), 22 (outpatient hospital-on campus) or 24 (ambulatory surgical center).

[3] Applies to Commercial claims.

**Distinct Service Modifiers**
Tufts Health Plan does not routinely compensate inappropriately billed distinct service modifiers billed with anesthesia codes (00100-01999, 99100-99140 or D9223).

Tufts Health Plan does not routinely compensate services that are inappropriately billed with distinct service modifiers (e.g., modifier 25 is only appropriate when appended to E&M services).

**Repeat Procedure by the Same or Another Physician**
Tufts Health Plan does not routinely compensate procedures appended with modifier 76 (repeat procedure/same physician) when the same procedure code has not been billed by the same Provider ID on the same date of service, or within the post-operative period of the billed procedure.

**Co-Surgeons Concept Does Not Apply**
Tufts Health Plan does not routinely compensate procedures designated as 'co-surgeon concept does not apply.'

**Co-Surgeons Not Allowed**
Tufts Health Plan does not routinely compensate procedures billed with modifier 62 that do not warrant a co-surgeon.

**Co-Surgeons Not Billing with Modifier 62**
Tufts Health Plan does not routinely compensate procedures billed without modifier 62 if a claim for the same procedure code billed with modifier 62 by a different provider has been previously processed.

## DOCUMENT HISTORY

- January 2021: Added edit for anatomical modifiers, effective for dates of service on or after April 1, 2021; updated effective date for changes to modifier reimbursement process to February 25, 2021
- November 2020: Updated effective date for policy regarding changes to reimbursement process for some modifiers for dates of services on or after February 26, 2021
- August 2020: Added policy regarding changes to reimbursement process for some modifiers for dates of services on or after December 1, 2020
- February 2020: Added billing instructions for assistant surgeon; added claim edits for Tufts Health Public Plans
- July 2019: Added claim edits for Tufts Health Public Plans
- May 2019: Added Tufts Health Public Plans; clarified Modifier 25 language
- October 2018: Added existing KX modifier usage
- August 2018: Added claim edits for consistency of reduced or discontinued services between professional and facility providers, effective for dates of service on or after October 1, 2018
- June 2018: Template updates; added Tufts Medicare Preferred HMO/Tufts Health Plan SCO inclusion
- July 2017: Added anatomical modifier edit effective for dates of service on or after October 1, 2017
- January 2017: Template updates
- September 2015: Template conversion, template updates
- July 2015: Added policy regarding submitting therapy modifiers for non-therapy services effective for dates of service on or after October 1, 2015, template updates
- May 2015: Added changes to Modifier 25 policy, effective for dates of service on or after July 1, 2015, template updates
- February 2015: Added requirement for submission of modifier JW, effective for dates of service on or after April 1, 2015

## AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves 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 a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication 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 requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.