Commercial Modifier Tables

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)

☐Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

This document applies to Tufts Health Plan contracting providers. Modifiers contained in this document may have an impact to claim payment. References to fee schedules are not a guarantee of payment.

Tufts Health Plan follows AMA CPT/HCPCS coding guidelines and accepts all standard modifiers submitted in accordance with the appropriate CPT/HCPCS procedure code(s). 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.

The modifiers in the table below directly impact fees and may also have bearing on which fee is applicable. For a complete list of modifiers, refer to the most current CPT/HCPCS guidelines.

Note: Modifiers indicated with an asterisk require additional documentation and/or operative notes to be submitted with the claim supporting the use of the modifier(s).

Modifier	Description	Compensation Impact/Notes
22*	Identifies a procedural service that requires substantially more work than the CPT code describes, and when no other procedure code or add-on codes can describe the service's increased complexity	Supporting documentation is reviewed by a medical director for additional compensation • May only be reported with procedure codes that have a global period of 0, 10, or 90 days • Do not appended to E&M codes
25[2]	Significant, separately identifiable E&M service	50% of Tufts Health Plan fee schedule/allowed amount on the E&M service
26	Professional component	Tufts Health Plan fee schedule/professional component allowed amount
33	To identify a preventive service for which patient cost sharing does not apply. Append to a CPT code that is a diagnostic/treatment service being performed as a preventive service.	Tufts Health Plan fee schedule/allowed amount
50	Bilateral procedure	150% of Tufts Health Plan fee schedule/allowed amount
51*	Multiple procedure	50% of Tufts Health Plan fee schedule/allowed amount
52*	Reduced services	70% of Tufts Health Plan fee schedule/allowed amount
53*	Discontinued procedure	20% of Tufts Health Plan fee schedule/allowed amount
54	Surgical care only	80% of Tufts Health Plan fee schedule/allowed amount
55	Postoperative management only	10% of Tufts Health Plan fee schedule/allowed amount
56	Preoperative management only	10% of Tufts Health Plan fee schedule/allowed amount
59*[3]	Distinct procedural service	50% of Tufts Health Plan fee schedule/allowed amount
62*	Two surgeons	62.5% of Tufts Health Plan fee schedule/allowed amount
66	Surgical team	62.5% of Tufts Health Plan fee schedule/allowed amount
73	Discontinued outpatient procedure prior to anesthesia administration	50% of Tufts Health Plan fee schedule/allowed amount

[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.
[2] Applies to professional and outpatient claims
[3] Modifier 50 is the only modifier that will have additional impact to compensation when submitted with Modifier 59.

Modifier	Description	Compensation Impact/Notes
74	Discontinued outpatient procedure after anesthesia administration	70% of Tufts Health Plan fee schedule/ allowed amount
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	70% of Tufts Health Plan fee schedule/allowed amount
80	Assistant surgeon	16% of Tufts Health Plan fee schedule/allowed amount
81	Minimum assistant surgeon	16% of Tufts Health Plan fee schedule/allowed amount
82	Assistant surgeon (when qualified resident surgeon not available)	16% of Tufts Health Plan fee schedule/allowed amount
AA	Anesthesia services performed personally by an anesthesiologist	Tufts Health Plan fee schedule/allowed amount
AD	Medical supervision by a physician, more than four concurrent anesthesia procedures	50% of the Tufts Health Plan fee schedule/allowed amount
AH[4][5]	Clinical psychologist (PhD, PsyD, EdD)	90% of Tufts Health Plan's applicable physician fee schedule/allowed amount
AJ	Clinical social worker (LICSW, LCSW)	75% of Tufts Health Plan's applicable physician fee schedule/allowed amount
AS	PA services for assistant surgeon	16% of Tufts Health Plan fee schedule/allowed amount
HM	Less than bachelor's degree level (LSWA)	65% of Tufts Health Plan's applicable physician fee schedule/allowed amount
HN	Bachelor's degree level (LSW)	65% of Tufts Health Plan's applicable physician fee schedule/allowed amount
HO	Master's degree level (LMHC, LMFT)	75% of Tufts Health Plan's applicable physician fee schedule/allowed amount
HP	Doctoral level (PhD, PsyD, EdD)	90% of Tufts Health Plan's applicable physician fee schedule/allowed amount
JW	Drug amount discarded/not administered to any patient	Tufts Health Plan fee schedule/allowed amount
KH	DME, initial claim, 1st month rental	Tufts Health Plan fee schedule/ allowed amount
KI	DME, 2nd and 3rd capped rental months	Tufts Health Plan fee schedule/ allowed amount
KJ	DME, 4th-13th capped rental months	75% of Tufts Health Plan fee schedule/allowed amount
KR	Rental item, partial month	Tufts Health Plan fee schedule/rental fee
LL	Lease/rental	Tufts Health Plan fee schedule/rental fee
MS	6-month maintenance and servicing fee	Tufts Health Plan fee schedule/rental fee
RR	Rental equipment	Tufts Health Plan fee schedule/rental fee
QK	Medical direction of 2-4 concurrent anesthesia procedures involving qualified individuals	50% of the Tufts Health Plan fee schedule/allowed amount
QX	CRNA service, with medical direction by a physician	50% of the Tufts Health Plan fee schedule/allowed amount
QY	Medical direction of one CRNA by an anesthesiologist	50% of the Tufts Health Plan fee schedule/allowed amount
SA	Nurse practitioner—Nonsurgical (PCNS, APRN, RNCS)	85% of Tufts Health Plan's applicable physician fee schedule/allowed amount
SL	State-supplied vaccine	0% of Tufts Health Plan fee schedule/ allowed amount

[4] Codes 96101-96103 and 96118-96120 are excluded from modifier logic when billed with modifier AH and HP.
[5] Tufts Health Plan requires provider organization–affiliated psychiatrists to append appropriate modifiers for services provided by a non-M.D. clinician in their office. The modifiers will affect compensation according to clinician type.

Modifier	Description	Compensation Impact/Notes
SQ[6]	Item ordered by home health	Tufts Health Plan fee schedule/allowed amount. SQ allows the claim to process under the home care benefit without a copayment or benefit maximum
TD	Registered nurse (PCNS, APRN, RNCS)	85% of Tufts Health Plan's applicable physician fee schedule/allowed amount
TE	LPN or LVN	65% of Tufts Health Plan's applicable physician fee schedule/allowed amount
U2	Medicare/Medicaid Care Level II	Tufts Health Plan fee schedule/allowed amount + 31.4% of fee scheduled amount (assigned by the state of MA to be used for Early Intervention Services)
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)	50% of Tufts Health Plan fee schedule/ allowed amount
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner	50% of Tufts Health Plan fee schedule/ allowed amount
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure	50% of Tufts Health Plan fee schedule/ allowed amount
XU	Unusual nonoverlapping service, the use of a service that is distinct because it does not overlap usual components of the main service	50% of Tufts Health Plan fee schedule/ allowed amount

Common modifiers that may affect claims adjudication are included but not limited to those contained in the table below. The absence or presence of a given modifier may result in a claim denial.

Modifier	Description
BO	Orally administered nutrition, not by feeding tube
CR	Catastrophe/disaster
GO	Services delivered under an outpatient occupational therapy plan of care
GP	Services delivered under an outpatient physical therapy plan of care
GN	Services delivered under an outpatient speech therapy plan of care
24	Unrelated E&M service by the same physician during a post-operative period
57	Decision for surgery
58	Staged or related procedure or service by the same physician during the postoperative period
76	Repeat procedure by the same physician
77	Repeat procedure by another physician
79	Unrelated procedure or service by the same physician during the post-operative period
90	Reference (Outside) laboratory

ADDITIONAL RESOURCES

Modifier Payment Policy
Drugs and Biologicals Payment Policy
DME Payment Policy
Imaging Professional Payment Policy

DOCUMENT HISTORY

- June 2018: Template updates; moved content-specific modifiers to their respective payment policies
- September 2017: Added existing compensation rate for 78 modifier
- May 2016: Updated SA modifier billing requirements effective July 1, 2016

[6] SQ modifier is to be used with HCPCS DME code(s) to indicate item ordered for home health services and must be submitted in the primary modifier field. Refer to the DME Payment Policy for additional information.

- January 2016: Added information regarding MA and RI CRNAs
- September 2015: Template conversion, template updates
- May 2015: Added changes to the Modifier 25 policy, effective for dates of service on or after July 1, 2015
- February 2015: Added modifier JW, effective for dates of service on or after April 1, 2015
- December 2014: Added modifiers XE, XP, XS and XU, effective for dates of service on or after January 1, 2015, template updates.
- September 2014: Template updates
- May 2014: Document reviewed, not content changes, template updates.
- September 2013: Template conversion
- May 2012: Reformatted document for clarity, added information regarding multiple modifiers effective for claims adjudicated on or after July 1, 2012 and modifier 33 implementation, effective for claims dates of service on or after July 1, 2012.
- March 2012: Updated CareLink disclaimer language
- January 1, 2012. Added information regarding modifiers 33 and 59.
- October 2011: Added information regarding multiple modifiers effective for dates of service on or after
- May 2011: Provided additional instruction regarding the use of modifier 25. Added or updated codes AH, AJ, HP, HM, HN, HO, SA, TD, and TE with information about provider-type compensation impact for non-M.D. clinicians providing certain services in a psychiatrist's office, effective for dates of service on or after July 1, 2011.
- November 2004: Document originated

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 an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/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.