Modifier Tables

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)

This document applies to Tufts Health Public Plans 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 Public Plans follows industry-standard 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. Modifier use is subject to change based on changes to industry standards.

The modifiers in the table below directly impact fees. These modifiers 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	May only be reported with procedure codes that have a global period of 0, 10, or 90 days Do not append to E&M codes
25[1]	Significant, separately identifiable E&M service	50% of Tufts Health Public Plans fee schedule/ allowed amount on the E&M service
50	Bilateral procedure	150% of the Tufts Health Plan fee schedule/ allowed amount
51	Multiple procedures performed on the same member during the same operative session or on the same day	50% of the Tufts Health Public Plans fee schedule/ allowed amount
54	Surgical care only	85% of Tufts Health Public Plans fee schedule/ allowed amount
55	Postoperative management only	15% of Tufts Health Public Plans fee schedule/ allowed amount
56	Preoperative management only	15% of Tufts Health Public Plans fee schedule/ allowed amount
59*[2]	Distinct procedural service	50% of Tufts Health Plan fee schedule/allowed amount

[1] Applies to professional claims.
[2] Modifier 50 is the only modifier that will have additional impact to compensation when submitted with Modifier 59.

Modifier	Description	Compensation Impact/Notes
62*[3]	Two Surgeons	62.5% of Tufts Health Plan fee schedule/allowed amount
80*	Assistant surgeon	15% of Tufts Health Public Plans fee schedule/ allowed amount
81*	Minimum assistant surgeon	15% of Tufts Health Public Plans fee schedule/ allowed amount
82*	Assistant surgeon (when qualified resident surgeon not available)	15% of Tufts Health Public Plans fee schedule/ allowed amount
AH	Clinical psychologist (PhD, PsyD, EdD)	100% of Tufts Health Public Plans fee schedule/ allowed amount
AJ	Clinical social worker (LICSW, LCSW)	75% of Tufts Health Public Plans fee schedule/ allowed amount
AS*	PA services for assistant surgeon	15% of Tufts Health Public Plans fee schedule/ allowed amount
EP	Service provided as part of Medicaid EPSDT program	137% of Tufts Health Public Plans applicable fee schedule/allowed amount
HM	Less than bachelor's degree level (LSWA)	0% (informational only)
HN	Bachelor's degree level (LSW)	0% (informational only)
HO	Master's degree level (LMHC, LMFT)	75% fee schedule/allowed amount
HP	Doctoral level (PhD, PsyD, EdD)	100% fee schedule/allowed amount
QK	Medical direction of 2-4 concurrent anesthesia procedures involving qualified individuals	50% of Tufts Health Public Plans fee schedule/ allowed amount
QX	CRNA service with medical direction by a physician	50% of the Tufts Health Public Plans fee schedule/ allowed amount
QY	Medical direction of one CRNA by an anesthesiologist	50% of the Tufts Health Public Plans fee schedule/ allowed amount
SA	Nurse practitioner-Non-surgical (PCNS, APRN, RNCS)	Lesser of: 80% of actual (billed) charge OR 80% of 85% MD fee schedule
TD	Registered nurse (PCNS, APRN, RNCS)	0% (informational only)
TE	LPN or LVN	0% (informational only)
UE	Used durable medical equipment	75% of Tufts Health Public Plans 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
TC	Technical Component
24	Unrelated E&M service by the same physician during a postoperative period

[3] When two surgeons are required to perform a specific procedure, each surgeon must file a claim for the procedure with Modifier 62. In separate operative reports, each surgeon must document his or her level of involvement and include a copy of the operative note when reporting the service.

26	Professional Component
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 postoperative period
90	Reference (outside) laboratory

DOCUMENT HISTORY

- July 2020: Added existing provider-specific behavioral health modifiers
- March 2020: Added existing documentation for modifier 22
- February 2020: Added existing documentation requirements for modifiers 62, 80, 81, 82, AS
- October 2019: Added existing compensation rate for modifier 50
- May 2019: Document created

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.