

Procedure to Modifier Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

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

Reimbursement Guidelines

This policy addresses the appropriate use of modifiers with individual CPT and HCPCS procedure codes.

UnitedHealthcare Community Plan sources its procedure code to modifier relationships to methodologies used and recognized by third-party authorities. Those methodologies can be definitive or interpretive. A Definitive Source is one that is based on very specific instructions from the given source. An Interpretive Source is one that is based on an interpretation of instructions from the identified source.

Modifiers that have no third-party industry standard source, policies or guidelines to direct development of specific coding relationships or edits, are allowed with all CPT codes and HCPCS codes. Modifiers to which this policy does not apply are found on the “Modifier Bypass” list.

[Modifier Bypass List](#)

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

For example, the description for modifier 25 (Significant, Separately Identifiable Evaluation and Management (E/M) Service by the Same Physician on the Same Day of the Procedure or Other Service) specifies that it is to be reported with an (E/M) service. Therefore, a surgical code, e.g., 62263, appended with modifier 25 will not be reimbursed because according to its description it should only be appended to E/M codes.

Effective with dates of service on or after July 1, 2020 UnitedHealthcare Community Plan aligns with CMS and requires HCPCS modifiers GN, GO or GP to be reported with the codes designated by CMS as always therapy services. These codes are considered always therapy services, regardless of who performs them, and require one of the applicable therapy modifiers (GN, GO, or GP) to indicate that they are furnished under a physical therapy, occupational therapy or speech-language pathology plan of care.

For a list of codes requiring a modifier, please see the attachment below.

Refer to the UnitedHealthcare Community Plan “Modifier Reference Policy” for a listing of UnitedHealthcare Community Plan reimbursement policies that discuss specific modifiers and their usage within those reimbursement policies.

Definitions

Definitive Source	Definitive Sources contain the exact codes, modifiers or very specific instructions from the given source.
Interpretive Source	An edit source that includes guidelines; however, no exact or specific code or modifier information is listed. Therefore, an interpretation must be made as to what codes correlate to the guidelines. Additionally, an interpretation may be applied to surrounding or similar codes based on related definitively sourced edits.

State Exceptions

Arizona	<p>Arizona has a state specified procedure to modifier list for all products, except for LTC. Arizona LTC has a specified procedure to modifier list.</p> <p>Per Arizona State Regulations, the state is excluded from Always Therapy Required Modifier requirement.</p> <p>Per Arizona State Regulations, the following codes are exempt from the policy:</p> <ul style="list-style-type: none"> • T1016 when billed with modifier GT
California	<p>Per California State Regulations, effective 4/1/2018, the following codes are exempt from the policy:</p> <ul style="list-style-type: none"> • 93797, 93798, G0422 and G0423 when billed with modifier 24 or 25 • A0427, A0429 & A0433 when billed with modifier UN
Florida	<p>Per Florida State Regulations, the following codes are exempt from the policy:</p> <ul style="list-style-type: none"> • H0031, H0032, H2012, H2014 and H2019 when billed with modifier BA for FLMMA only <p>Per Florida State Requirements, Modifier GT must be appended to all Telemedicine/Telehealth codes. Claim lines with Modifier 95 or GQ will deny.</p>


	Florida FLMMA has a specific list of codes that are not covered with Modifier JW
Hawaii	Per Hawaii State Regulations, the following codes are exempt from the policy: <ul style="list-style-type: none"> • E1399 when billed with modifier KL • T1019 & T2033 billed with modifier 22 • 97157 when billed with modifier UN, UP, UQ, UR or US
Iowa	Per Iowa State Regulations, the following codes are exempt from the policy: <ul style="list-style-type: none"> • S9434 and S9435 when billed with modifier BO
Kansas	Kansas has a state specified procedure to modifier list Per Kansas State Regulations, the state is excluded from Always Therapy Required Modifier requirement.
Missouri	Per Missouri State Regulations, effective 5/1/2017, the following codes are exempt from the policy: <ul style="list-style-type: none"> • 99429 when billed with a modifier EP or modifier 59 • 96116, 99429 & H0037 when billed with modifier 52 • H2000 & H2001 when billed with modifier 22 • A5200 B4034 B4035 B4036 B4081 B4082 B4083, B4087 B4088 B4103 B4104 B4149 B4150 B4152 B4153 B4154, B4155 B4157 B4158 B4159 B4160 B4161 B4162 B9002 B9998, E0776 S9434 S9435 when billed with a BA modifier <p>Per Missouri State Regulations, the state is exempt from the Always Therapy Modifier requirement.</p> <p>Per Missouri State Regulations, the following codes are exempt from the policy:</p> <ul style="list-style-type: none"> • 99381-99397 when billed with modifier AR <p>Per Missouri State Regulations modifier QY is not allowed for billing purposes. Modifiers 95, G0, GQ, and GT are not allowed for billing purposes, except in POS 02 (telehealth) and 03 (school).</p>
Nebraska	Per Nebraska State Regulations, effective 1/1/2017, the following codes are exempt from the policy: <ul style="list-style-type: none"> • 96101, H0001, H0031, H0040 and H2012 when billed with 52 modifier • H2000 when billed with SK modifier • E0431 and E0434 when billed with QE modifier • E0443 and E0444 when billed with QE, QF or QG modifier
New York	Due to State Regulations: <ul style="list-style-type: none"> • HCPCS codes G8510 and G8431 are allowed with modifier HD • S5165 when billed with modifiers V1, V2 and V3
Ohio	Per Ohio State Regulations, the following codes are exempt from the policy: <ul style="list-style-type: none"> • H0006 when billed with modifier US, for MMP product only • H0014 when billed with modifier UT, for the MMP product only • H0014 when billed with modifier AT • S5000 and S5001 when billed with modifier HD • 0366T, 0367T, 0371T, 0372T when billed with modifiers UN, UP, UQ, UR or US • J8499 when billed with modifier HG, HO, SA or UC
Tennessee	Per Tennessee State Regulations, the following codes are exempt from the policy: <ul style="list-style-type: none"> • A0100, A0110, A0120, A0130, A0140, A0160, A0170, A0180, A0190, A0200, A0210 and A0420, when billed with 76 modifier • T2025 when billed with modifiers US and SE • T2019 when billed with modifier US • H0047 when billed with modifier HG
Texas	Per Texas State Regulations, the state is excluded from the Always Therapy Modifier requirement.


	<p>Per Texas State Regulations, the following codes are exempt from the policy:</p> <ul style="list-style-type: none"> • 90901, 90911, 92507, 92508, 92521-92524, 92526, 92610, 97001, 97002, 97003, 97004, 97012, 97016, 97018, 97022, 97024, 97026, 97028, 97032-97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97530, 97535, 97537, 97542, 97597, 97598, 97750, 97760-97762, 97799, 97802-97804, H0016, H0031, H0047, H0050, H2017, H2035, J1265, S8990, and S9152 when billed with modifier AT • H2015, H2023, H2025, S5125, S5151, T1005, T1019, T2017, and T2021 when billed with modifier US. • 59812, 59820, 59821 and 59830 when billed with modifier G7 • H2023 and H2025 when billed with modifier 99 • H0047 and S4995 when billed with modifier HF • 99211, 99356, T1015, Q3014, G0407, G0425, G0426 when billed with modifier 95 <p>Per Texas State Regulations, effective 1/1/2019, modifier U1 is not allowed with HCPC T4528.</p> <p>Per Texas State Regulations, modifier JW is not allowed for billing purposes.</p>
Washington	<p>Per Washington State Regulations, the state is excluded from Always Therapy Required Modifier requirement.</p> <p>Per Washington State Regulations, the following codes are exempt from the policy:</p> <ul style="list-style-type: none"> • B4034-B4036, B4081-B4083, B4087, B4088, B4100, B4102-B4104, B4149, B4150, B4152-B4155 and B4157-B4162 when billed with BA modifier • 0371T, 0366T, and 0367T when billed with modifiers UN, UP, UQ, UR and US
Wisconsin	<p>Per Wisconsin State Regulations, the following codes are exempt from the policy:</p> <ul style="list-style-type: none"> • 27096 when billed with both a SG modifier and place of service 24 • H0002 when billed with AM modifier • 90001 when billed with HG modifier • 99199 when billed with modifier HN and place of service 4, 12, 13, 14, 33, 34, 55, 56 and 99

Questions and Answers

	<p>Q: Why aren't all CPT and HCPCS modifiers addressed in this policy?</p> <p>A: The intent of the Procedure to Modifier Policy is to validate appropriate modifier usage and is not meant to address all possible modifier situations.</p>
1	<p>Modifiers excluded from this policy may have:</p> <ol style="list-style-type: none"> a) no third-party industry standard source, policies or guidelines to direct development of specific coding relationships or edits; b) a more detailed reimbursement methodology than the scope of this policy is intended; e.g. 26, TC, AA, QK; or c) Contractual or benefit coverage implications.

Attachments:

 UnitedHealthcare Community Plan Modifier Bypass List	<p>A list of modifiers that bypass the Procedure to Modifier Policy. (This list does not apply to the Arizona and Kansas Health Plans)</p>
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 UnitedHealthcare Community Plan HCPCS/CPT Required Modifier Table	A list of HCPCS/CPT codes and their required modifiers
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Resources

Individual state Medicaid regulations, manuals & fee schedules

American Medical Association, *Current Procedural Terminology (CPT®) Professional Edition* and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

History

5/21/2020	Policy Version Change State Exceptions Section: Missouri updated
5/3/2020	Policy Version Change State Exceptions Section: New York updated
3/29/2020	Policy Version Change Attachments Section: Updated the Modifier Bypass List State Exceptions Section: Texas updated and Louisiana removed Removed all files and references to Louisiana contained in the body of the policy, information has been moved to the "Louisiana Only" policy
3/10/2020	Policy Version Change Attachments Section: UnitedHealthcare Community Plan Modifier Bypass List updated
2/23/2020	Policy Version Change Reimbursement Guidelines Section: Removed Biosimilar and added Always Therapy verbiage Attachment Section: List Updates State Exceptions Section: Added Always Therapy Modifier requirement exclusion verbiage to AZ, KS, LA, MO, and WA Q&A Section: Removed Q&A #2 (biosimilar drugs)
2/16/2020	Policy Version Changed State Exceptions section: updated FL, removed NM
1/3/2020	Annual Policy Version Change Reimbursement Guideline Section: updated transmittal History section: Archived history prior to 1/1/2018
12/8/2019	State Exceptions section: updated CA Version Changed History section: Archived history prior to 1/1/2017
10/6/2019	State Exceptions section: updated NY and FL
9/29/2019	State Exceptions section: updated TX

9/15/2019	State Exceptions section: Updated MO- Per Missouri State Regulations modifier QY is not allowed for billing purposes
9/8/2019	State Exceptions section: updated TX verbiage with following information • H2015, H2023, H2025, S5125, S5151, T1005, T1019, T2017, and T2021 when billed with modifier US.
4/7/2019	State Exceptions section: updated HI
3/17/2019	State Exceptions section: updated NE
3/3/2019	Attachments section: updated modifier bypass list
2/8/2019	State Exceptions section: updated NE
1/13/2019	State Exceptions section: updated NY
1/1/2019	Annual Policy Version Change Attachments section: updated Procedure to modifier bypass list State Exceptions section: updated Texas History section: Entries prior to 1/1/2017 archived
11/18/2018	State Exceptions section: updated MO and added NY
11/11/2018	Policy name change to Procedure to Modifier Policy, Professional State Exceptions section: updated MO and TN
8/24/2018	Reimbursement Guidelines and Attachments sections updated: Biosimilar added effective & term dates
7/1/2018	State Exceptions section: Added California
6/13/2018	State Exceptions section: Updated Missouri Attachments section: Biosimilar requirements removed
5/20/2018	State Exceptions section: Updated Iowa, Nebraska & Ohio
4/1/2018	Annual Policy approval date updated Attachments Section: HCPCS/CPT Required Modifier List Q&A #2 updated
2/12/2018	Attachments section updated
1/14/2018	State Exceptions section: Updated Ohio
1/8/2018	State Exceptions section: Updated Nebraska
1/5/2018	Annual Policy Version Change State Exceptions section: Removed Kansas History Section: Entries prior to 1/1/2016 archived
6/13/2011	Policy posted by UnitedHealthcare Community & State

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