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.

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 the Healthcare Common Procedure Coding System (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" table.

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	Arizona has a state specified procedure to modifier list for all products, except for LTC. Arizona LTC has a specified procedure to modifier list. Per Arizona State Regulations, the state is excluded from Always Therapy Required Modifier requirement.
California	Per California State Regulations, the state is excluded from Always Therapy Required Modifier requirement. Per California State Regulations, effective 4/1/2018, the following codes are exempt from the policy: • 93797, 93798, G0422 and G0423 when billed with modifier 24 or 25 • A0427, A0429 & A0433 when billed with modifier UN Per California State Regulations the following codes are exempt from the policy: • 92132, 92133, 92134, 92201, 92202, 92227, 92228, 92229, 92235, 92240 when billed with modifier 50 • HCPC Codes G8431 and G8510 can be billed with modifier HD

Florida	Per Florida State Regulations, the following codes are exempt from the policy: • H0031, H0032, H2012, H2014 and H2019 when billed with modifier BA for FLMMA only Per Florida State Requirements, Modifier GT must be appended to all Telemedicine/Telehealth codes. Claim lines with Modifier 95 or GQ will deny. Per Florida contractual agreement, LTC HCBS are excluded from this policy. Florida FLMMA specific list of codes that are not covered with Modifier JW.
Hawaii	Per Hawaii State Regulations, the following codes are exempt from the policy: • E1399 when billed with modifier KL • T1019, T2033 & T2022 with modifier 22 • 97157 when billed with modifier UN, UP, UQ, UR or US • Procedures billed with modifier TB
Kansas	Kansas has a state specified procedure to modifier list Per Kansas State Regulations, the state is excluded from Always Therapy Required Modifier requirement.
Kentucky	The state of Kentucky does not reimburse modifiers, 66, 22, 63, 54, 55, 56, and JW. Kentucky will be excluded from polices that reference modifiers 66, 22, 63, 54, 55 and/or 56. Per state regulations, 90461 billed with SL modifier will not reimburse.
Maryland	Per State Regulations, the delivery of Telehealth/Telemedicine eligible services must be reported with Modifier GT; Modifiers 95 and GQ are not allowed and will deny if billed. CPT 99600 with GT modifier is not payable in POS 4 and 99. Per State Regulations, CPT 99401 requires modifier CR.
Minnesota	Per Minnesota State Regulations, modifiers 95 and GQ are not allowed except when billed in a POS 02 and/or POS 10. HCPCS T1013 with the 52 modifier is allowed
Missouri	Per Missouri State Regulations, effective 5/1/2017, the following codes are exempt from the policy: • 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 and S9435 when billed with a BA modifier Per Missouri State Regulations, the state is exempt from the Always Therapy Modifier requirement. Per Missouri State Regulations, the following codes are exempt from the policy: • 99381-99397 when billed with modifier AR 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).
Nebraska	Per Nebraska State Regulations, effective 1/1/2017, the following codes are exempt from the policy: • H0001, H0031, H0040 and H2012 when billed with modifier 52 • E0431 and E0434 when billed with QE modifier • E0443 and E0444 when billed with QE, QF or QG modifier
New Jersey	Per New Jersey State Regulations modifier JW is not a covered modifier and will deny when billed.

	Per New Jersey State Regulations, code E0603 is allowed with modifier SC. Per New Jersey State Regulations, effective 1/1/2020, the following codes are exempt from the policy: • Always Therapy codes 96164, 96165, 97129, 97130, 97535, 97150, 97110, 92507, 92508 and 96153 when billed with modifiers 96 and 59 • S8990 when billed with modifiers 96 and HQ • G0515 when billed with modifier 96 • 99203 when billed with modifiers FP and 22
New York	Due to State Regulations: • HCPCS codes G8510 and G8431 are allowed with modifier HD • S5165, T2028 and T2039 when billed with modifiers V1, V2 and V3
North Carolina	Per North Carolina Regulations: • CPT 99401 must be reported with modifier CR; if not reported, will deny. • CPT 96110, 96112, 96113, 96130 and 96131 with GT modifier are not payable in POS 03 • CPT codes 11055, 11056, 11057, 11719, 11720, 11721, and G0127 must be reported with Q7, Q8, or Q9 modifier; if not reported, will deny. • CPT 1003F allows when billed with modifier SE • Orthotic and prosthetic HCPCS codes must be reported with RT or LT modifier; if not reported, will deny. Applies only to items that can be used for one side of the body or the other, but not for codes that are bilateral or describe a pair. • North Carolina allows HCPCS code G0330 with modifier SG
Rhode Island	Per Rhode Island State Regulations, the following codes are exempt from the policy: T1005 when billed with modifier UN or UP
Tennessee	Per Tennessee State Regulations, the following codes are exempt from the policy: • A0100, A0110, A0120, A0130, A0140, A0160, A0170, A0180, A0190, A0200, A0210 and A0420, when billed with modifier 76 • 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. Per Texas State Regulations, the following codes are exempt from the policy: • 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 • Per state regulations, CPT 87637 must be billed with Modifier QW • Per state regulations, codes billed with GZ modifier will not reimburse Per Texas State Regulations, effective 1/1/2019, modifier U1 is not allowed with HCPC T4528.
Virginia	Per Virginia State Regulations, modifiers HA and HB are not allowed when billed with procedure code H0035 and will deny if billed. Per Virginia State Regulations, codes T1024, T1027, T1026, T1015, G0151, G0152, G0153, G0495 are to be billed with U1 modifier for Reimbursement Category 1 Providers.

Washington	Per Washington State Regulations, the state is excluded from Always Therapy Required Modifier requirement. Per Washington State Regulations, HCPC code T1016 will deny when billed with HW modifier Per Washington State Regulations, the following codes are exempt from the policy: • B4034-B4036, B4081-B4083, B4087, B4088, B4100, B4102-B4104, B4149, B4150, B4152-B4155 and B4157-B4162 when billed with BA modifier • G2012 is reimbursable when billed with the CR modifier in any modifier field Per Washington State Regulation, the delivery of Telehealth/Telemedicine audio only eligible services must be reported with Modifier 93 and/or FQ: • 59400, 59425, 59426, 59510, 925074, 92521, 92522, 92523, 96127, 96156, 96158, 96159, 96160, 96161, 96167, 96168, 96170, 96171, 97375, 97802, 97803, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355, 99407, G0108, S9445, S9470, S9482, T1002, T1016, T1017, T1027
Washington DC	Per District Regulations, the delivery of Telehealth/Telemedicine eligible services must be reported with Modifier GT; Modifiers 95 and GQ are not allowed and will deny if billed. Due to District Regulations: • Per District Regulations, 59840, 59841, 59850, 59851,59852, 59866, S0190, S0191. S0199 require G7 modifier
Wisconsin	Per Wisconsin State Regulations, Modifier 50 is not allowed with procedure codes A6504-A6508, A6530-A6538, A6545, A6549, S8420-S8429. Modifiers LT and RT must be billed to identify laterality when these codes are billed. Per Wisconsin State Regulations, Modifier 26 is required for G0399 in POS 05, 07, 11, 19, 22, 49, 50, 71, 72. Per Wisconsin State Regulations, the following codes are exempt from the policy: • 27096 when billed with both a SG modifier and place of service 24 • H0002 when billed with AM modifier • 99001 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 Per State Regulations, Wisconsin requires claims for ambulance services to include origin and destinations modifiers, as well as trip modifiers (U1-U6). Per Wisconsin State Regulations Modifier U1 or U3 is required to be billed with T1013

Questions and Answers	
1	**Q:** Why aren't all CPT and HCPCS modifiers addressed in this policy? **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. Modifiers excluded from this policy may have: 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	
Modifier Bypass List	A list of modifiers that bypass the Procedure to Modifier Policy. (This list does not apply to the Arizona and Kansas Health Plans)
HCPCS/CPT Required Modifier Table	A list of HCPCS/CPT codes and their required modifiers
Arizona Procedure to Modifier List	A list of HCPCS/CPT codes and their required modifiers for the state of Arizona only
Florida List of Codes Not Allowed with Modifier JW	List of Codes Not Allowed with Modifier JW for the state of Florida only

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

4/28/2024	Policy Version Change Attachment Section updated: Arizona Procedure to Modifier List updated
4/14/2024	Policy Version Change Attachment Section updated: Arizona Procedure to Modifier List updated History Section: Entries prior to 4/14/2022 archived
3/24/2024	Policy Version Change Attachment Section updated: Arizona Procedure to Modifier List added
3/17/2024	Policy Version Change State Exceptions section: Washington DC updated History Section: Entries prior to 3/17/2022 archived
2/9/2024	Policy Version Change State Exceptions section: Wisconsin updated
2/4/2024	Policy Version Change State Exceptions section: Kentucky updated History Section: Entries prior to 2/4/2022 archived
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10/08/2023	Policy Version Change State Exceptions section: Washington updated
9/10/2023	Policy Version Change State Exceptions section: North Carolina updated

7/23/2023	Policy Version Change State Exceptions section: Rhode Island updated
7/9/2023	Policy Version Change State Exceptions section: Hawaii updated
6/25/2023	Policy Version Change State Exceptions section: New Jersey updated
6/18/2023	Policy Version Change State Exceptions section: North Carolina updated
5/21/2023	Policy Version Change State Exceptions section: New Jersey, Virginia and Minnesota updated
5/1/2023	Annual Policy Version Change Header: Updated Branding
3/26/2023	Policy Version Change State Exceptions section: Washington and Hawaii
3/19/2023	Policy Version Change State Exceptions section: North Carolina
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6/13/2011	Policy posted by UnitedHealthcare Community & State