Procedure to Modifier Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

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 Medicare Advantage reimbursement policies use 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 (CMS 1450). 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 resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage 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 Medicare Advantage enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents**. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

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** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.

Application

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 Medicare Advantage 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.

In accordance with correct coding, UnitedHealthcare Medicare Advantage 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 Medicare Advantage reimbursement policies.

For example, the description for modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service) specifies that it is to be reported with an Evaluation and Management (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.

Biosimilar Biological Products

Consistent with CMS, effective for dates of service on or after August 1, 2017 through March 31, 2018, UnitedHealthcare Medicare Advantage will require biosimilar biological products to include a modifier that identifies the pharmaceutical manufacturer of the specific product. Biosimilar drug codes reported without the required modifier will be denied.

The table below lists biosimilar HCPCS Codes, the product(s) that are associated with each code, and the corresponding required modifiers that are used to identify the product.

Biosimilar HCPCS Code	Product Brand names	Corresponding Required Modifier
Q5101 Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	Zarxio	ZA - Novartis/Sandoz
Q5102 Injection, Infliximab, Biosimilar, 10 mg	Inflectra	ZB - Pfizer/Hospira ZC - Merck/Samsung Bioepis

Therapy Services Requiring a Modifier

To better align with CMS, effective for claims processed after Sept. 1, 2018 received with date of service Jan. 1, 2018 and after, UnitedHealthcare Medicare Advantage will require one of the three therapy modifiers − GN, GO, or GP on specific sets of CPT/HCPCS codes in order to identify when each outpatient therapy (OPT) service is furnished under a Speech-language pathology (SLP), occupational therapy (OT) and physical therapy (PT) services plan of care. UnitedHealthcare Medicare Advantage will reject claims that do not contain one of the designated modifiers assigned by CMS.
Each code designated as “always therapy” must always be furnished under an SLP, OT, or PT plan of care, regardless of

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who furnishes them; and, as such, must always be accompanied by one of the therapy modifiers. In addition, several "always therapy" codes have been identified as discipline specific – requiring the GN modifier, the GO modifier, or the GP modifier where applicable.

The specific sets of CPT/HCPCS codes can be found at the following website.
https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html

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.

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 not addressed by 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, e.g., 33
2	**Q:** Does UnitedHealthcare Medicare Advantage require modifiers for biosimilar drugs? **A:** For dates of service on or after August 1, 2017 through March 31, 2018, UnitedHealthcare Medicare Advantage does require HCPCS codes for biosimilar drugs to have the modifier that corresponds to the pharmaceutical manufacturer.

Codes	
Modifier code section	
GN	Services delivered under an outpatient speech language pathology plan of care.
GO	Service delivered personally by an occupational therapist or under an outpatient occupational therapy plan of care.
GP	Services delivered under an outpatient physical therapy plan of care.

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Resources

www.cms.gov

https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html

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

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

History

Date	Change
1/04/2019	Annual Anniversary Date and Version Change • Changed verbiage in Biosimilar Biological Products section to align all LOB
9/19/2018	Policy Version Change • Enhancement: therapy codes and required modifiers added • Modifiers added in the codes section • Resource section updated
9/7/2018	• Policy number changed from 2018R0119B (new version) • Title change to add Professional
3/21/2018	List Update • Expired ZA, ZB, and ZC modifier requirement effective DOS 4/1/2018 • Version change • Q&A update
3/14/2018	Annual Review Version change
11/17/2017	List Update
8/1/2017	Policy Implemented by UnitedHealthcare Medicare Advantage
1/11/2017	Policy approved by the Reimbursement Policy Oversight Committee

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