UnitedHealthcare
Community Plan

REIMBURSEMENT POLICY
CMS-1500
Policy Number 2021R0119L

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 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 (This list does not apply to the Arizona and Kansas Health Plans)

23	26	33	47	50	54	55	56	62	66	78	79	80	81	82	90	91	99	AA	AD
AQ	AS	CB	CR	CS	EJ	G8	G9	GC	GE	GN	GO	GP	GQ	GT	HO	HP	JW	LT	NU
P1	P2	P3	P4	P5	P6	QK	QS	QW	QX	QY	QZ	RA	RB	RT	SL	SU	TC	TF	TH
TM	TS	U1	U2	U3	U4	U5	U6	U7	U8	U9	UA	UB	UC	UD	UF	UG	UH	UJ	

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.

UnitedHealthcare Community Plan HCPCS/CPT Required Modifier Table

Procedure Code	Required Modifier
92507	GP
92507	GO
92507	GN
92508	GP
92508	GO
92508	GN
92521	GN
92522	GN
92523	GN
92524	GN
92526	GP
92526	GO
92526	GN
92597	GN
92607	GN
92608	GP
92608	GO
92608	GN

Procedure Code	Required Modifier
97032	GO
97032	GN
97033	GP
97033	GO
97033	GN
97034	GP
97034	GO
97034	GN
97035	GP
97035	GO
97035	GN
97036	GP
97036	GO
97036	GN
97039	GP
97039	GO
97039	GN
97110	GP

Procedure Code	Required Modifier
97166	GO
97167	GO
97168	GO
97530	GP
97530	GO
97530	GN
97533	GP
97533	GO
97533	GN
97535	GP
97535	GO
97535	GN
97537	GP
97537	GO
97537	GN
97542	GP
97542	GO
97542	GN

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UnitedHealthcare Community Plan HCPCS/CPT Required Modifier Table

Procedure Code	Required Modifier
92609	GP
92609	GO
92609	GN
96125	GP
96125	GO
96125	GN
97012	GP
97012	GO
97012	GN
97016	GP
97016	GO
97016	GN
97018	GP
97018	GO
97018	GN
97022	GP
97022	GO
97022	GN
97024	GP
97024	GO
97024	GN
97026	GP
97026	GO
97026	GN
97028	GP
97028	GO
97028	GN
97032	GP

Procedure Code	Required Modifier
97110	GO
97110	GN
97112	GP
97112	GO
97112	GN
97113	GP
97113	GO
97113	GN
97116	GP
97116	GO
97116	GN
97124	GP
97124	GO
97124	GN
97139	GP
97139	GO
97139	GN
97140	GP
97140	GO
97140	GN
97150	GP
97150	GO
97150	GN
97161	GP
97162	GP
97163	GP
97164	GP
97165	GO

Procedure Code	Required Modifier
97750	GP
97750	GO
97750	GN
97755	GP
97755	GO
97755	GN
97760	GP
97760	GO
97760	GN
97761	GP
97761	GO
97761	GN
97763	GP
97763	GO
97763	GN
97799	GP
97799	GO
97799	GN
G0281	GP
G0281	GO
G0281	GN
G0283	GP
G0283	GO
G0283	GN
G0329	GP
G0329	GO
G0329	GN

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.

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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

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

90375	A9575	A9576	A9577	A9579	A9585	B4152	D0481	J0131	J0153
J0171	J0278	J0289	J0360	J0485	J0490	J0515	J0561	J0585	J0588
J0595	J0640	J0641	J0692	J0696	J0702	J0878	J0881	J0894	J1100
J1165	J1170	J1200	J1270	J1335	J1439	J1442	J1602	J1640	J1642
J1644	J1650	J1720	J1745	J1750	J1756	J1885	J1940	J2060	J2185
J2250	J2260	J2270	J2300	J2405	J2550	J2562	J2704	J2796	J2920
J2930	J3010	J3105	J3262	J3300	J3301	J3360	J3370	J3411	J3475
J3480	J3486	J3489	J7325	J7510	J7512	J8540	J9000	J9017	J9019
J9025	J9035	J9041	J9042	J9043	J9047	J9055	J9070	J9145	J9171
J9173	J9179	J9190	J9201	J9205	J9206	J9228	J9229	J9250	J9263
J9264	J9299	J9303	J9305	J9308	J9312	J9351	J9352	J9354	J9355
Q2050	Q4081	Q5103	Q5105	Q9967	Q9968	S0166			

Hawaii

Per Hawaii State Regulations, the following codes are exempt from the policy:

- E1399 when billed with modifier KL
- T1019 & T2033 billed with modifier 22
- 97157 when billed with modifier UN, UP, UQ, UR or US

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 81,82, AS, 52, 53, 62, 66, 22, 63, 54, 55 and 56. Kentucky will be excluded from polices that refence modifiers 81,82, AS, 52, 53, 62, 66, 22, 63, 54, 55 and/or 56.

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.

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<table>
<tr><td>Missouri</td><td>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).</td></tr>
<tr><td>Nebraska</td><td>Per Nebraska State Regulations, effective 1/1/2017, the following codes are exempt from the policy:
96101, H0001, H0031, H0040 and H2012 when billed with modifier 52
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</td></tr>
<tr><td>New Jersey</td><td>Per New Jersey State Regulations, the state is exempt from the Always Therapy Modifier requirement.
Per New Jersey State Regulations modifier JW is not a covered modifier and will deny when billed.</td></tr>
<tr><td>New York</td><td>Due to State Regulations:
HCPCS codes G8510 and G8431 are allowed with modifier HD
S5165 when billed with modifiers V1, V2 and V3</td></tr>
<tr><td>North Carolina</td><td>Per North Carolina Regulations, effective 06/22/2021 procedure code 99401 is only allowed with modifier 25, CR, GT & KX</td></tr>
<tr><td>Tennessee</td><td>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</td></tr>
<tr><td>Texas</td><td>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.</td></tr>
</table>

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Virginia	Per Virginia State Regulations, modifiers HA and HB are not allowed when billed with procedure code H0035 and will deny if billed.
Washington	Per Washington State Regulations, the state is excluded from Always Therapy Required Modifier requirement. 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 • 0371T, 0366T, and 0367T when billed with modifiers UN, UP, UQ, UR and US • G2012 is reimbursable when billed with the CR modifier in any modifier field
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 • 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

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.

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

9/15/2021	Policy Version Change State Exceptions Section: Arizona and North Carolina updated

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9/12/2021	Policy Version Change State Exceptions Section: Texas updated
8/22/2021	Policy Version Change State Exceptions Section: Wisconsin and Texas updated
8/15/2021	Policy Version Change State Exceptions Section: North Carolina updated
8/8/2021	Policy Version Change State Exceptions Section: Wisconsin updated
7/25/2021	Policy Version Change State Exceptions Section: North Carolina added
7/18/2021	Policy Version Change State Exceptions Section: Washington updated
7/11/2021	Policy Version Change State Exceptions Section: Virginia added Modifier Bypass List: updated to correct list State Exceptions Section: Florida updated
6/13/2021	Policy Version Change State Exceptions Section: Florida updated History Section: Entries prior to 6/13/2019 archived
5/21/2021	Policy Version Change Attachments Section: Removed attachment(s) and converted to table(s)
4/18/2021	Policy Version Change State Exceptions Section: New Jersey updated
1/1/2021	Annual Policy Version Change State Exception Section: Removed deleted codes from Ohio and added Kentucky section Attachment Section: Added Florida List of Codes Not Allowed with Modifier JW for Florida Only History section: Entries prior to 1/1/2019 archived
11/8/2020	Policy Version Change Attachments Section: UnitedHealthcare Community Plan Modifier Bypass List updated
10/11/2020	Policy Version Change State Exceptions Section: Tennessee and Texas updated. New Jersey added.
9/27/2020	Policy Version Change Attachments Section: UnitedHealthcare Community Plan Modifier Bypass List updated
9/13/2020	Policy Version Change State Exceptions Section: Maryland updated
7/19/2020	Policy Version Change State Exceptions Section: California updated; Iowa removed
7/12/2020	Policy Version Change State Exceptions Section: Tennessee updated
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

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	Attachments Section: UnitedHealthcare Community Plan Modifier Bypass List updated 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: Entries prior to 1/1/2017 archived
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.
6/13/2011	Policy posted by UnitedHealthcare Community & State

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