Modifier Payment Policy

Applicability

This Policy applies to the following Fallon Health products:

☒ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO (Medicaid-only)
☒ Summit Eldercare PACE
☒ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)

Policy

Modifiers are two-digit codes that may be added to the main procedure code. They are used to indicate that the procedure being reported has been altered by specific circumstances described by the modifier. The use of modifiers eliminates the need for separate procedure listings that may describe the modifying circumstances.

Note: The listing below does not represent the complete list of category-specific modifiers. For a complete list of modifiers and more information regarding the appropriate use of modifiers with individual codes, refer to the most current CPT and HCPCs guidelines.

Reimbursement

The Plan will accept up to four modifiers per claim line. Per Medicare guidelines, the modifier that affects payment must be submitted first.

Reimbursements listed in this section will be paid only if all Plan procedures and referral requirements are followed.

The presence or absence of one of the following modifiers may affect claims payment or result in a claim denial.

Click on one of the following hyperlinks to go directly to the corresponding modifier listing:

Advance Beneficiary Notice of Noncoverage (ABN) Modifiers

An Advance Beneficiary Notice of Noncoverage (ABN) is a written notice given to an Original Medicare beneficiary by a healthcare provider or supplier in advance of furnishing an item or service, when they believe that Original Medicare will deny some or all of the services or items as

not reasonable and necessary, or when a denial is anticipated based on provisions other than medical necessity, such as for statutory exclusions.

The GA, GX, GY, and GZ modifiers are required on claims when a provider is billing Original Medicare. These modifiers are not applicable when billing a Medicare Advantage Plan (for example, Fallon Health), therefore they are not required on claims.

Modifier	Description
GA	Waiver of liability statement issued as required by payer policy
GX	Notice of liability issued, voluntary under payer policy
GY	Notice of liability not issued, not required under payer policy
GZ	Item or service expected to be denied as not reasonable and necessary

Ambulance origin and destination modifiers

Single-digit modifiers for ambulance transport are used in combination in reporting services to CMS. The first digit indicates the transport's place of origin, and the second digit indicates the destination.

Modifier	Description
D	Diagnostic or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 facility)
G	Hospital-based ESRD/dialysis facility (hospital or hospital related)
H	Hospital
I	Site of transfer (for example, airport or helicopter pad) between types of ambulance
J	Freestanding/Non-hospital based ESRD/dialysis facility
N	Skilled nursing facility (1819 facility)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office on way to hospital (includes HMO non-hospital facility, clinic, etc.) (destination code only)

Other Ambulance Modifiers

Modifier	Description
CR	Catastrophe/disaster related
GA	Non-covered service, waiver of liability on file

GM	Multiple patients on one ambulance trip
GW	Service unrelated to hospice patient's terminal condition
GY	Statutorily excluded service
GZ	Service not reasonable and necessary
QJ	Incarcerated patient responsible to pay
QL	Patient pronounced dead after ambulance called/dispatched
QM	Ambulance service provided under arrangement by a provider of services (institutional-based providers)
QN	Ambulance service furnished directly by a provider of services (institutional-based providers)
TQ	Basic Life Support transport provided by a volunteer ambulance service
UN	Two Patients served
UP	Three patients served

Anatomic modifiers
Append to a service that is performed on the hands, feet, eyelids, coronary artery, or left and right side of the body.

Side of Body modifiers

Modifier	Description
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)

Eyelid modifiers

Modifier	Description
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid

Hand modifiers

Modifier	Description
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit

F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit

Feet modifiers

Modifier	Description
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit

Coronary artery modifiers

Modifier	Description
LC	Left circumflex coronary artery
LD	Left anterior descending coronary artery
LM	Left main coronary artery
RC	Right coronary artery

Anesthesia modifiers

Anesthesia services require one of the following modifiers:

Modifier	Description	Impact to Reimbursement
23	Unusual anesthesia	To indicate a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia.
47	Anesthesia by surgeon	Regional or general anesthesia provided by the surgeon may be reported by adding the modifier 47 to the basic service. (This

		does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures 00100–01999. • Reporting of this modifier is for informational purposes only. This service is not covered by the Plan.
AA	Anesthesia services performed personally by anesthesiologist.	
AD	Medical supervision by a physician: More than four concurrent anesthesia procedures.	Reimbursement will be additional three base units per procedure.
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.	Reimbursement will be at 50% of the allowable amount.
QS	Monitored anesthesia care services. The QS modifier must be submitted with modifiers –G8 and –G9.	Reimbursement will be at 50% of the allowable amount.
QX	CRNA service: With medical direction by a physician.	
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist.	Reimbursement will be at 50% of the allowable amount.
QZ	CRNA service: Without medical direction by physician.	Reimbursement per Medicare guidelines.
Note: The reporting of physical status modifiers or qualifying circumstances (99100 – 99140) do not affect reimbursement.		

Durable Medical Equipment (DME) Modifiers

For information on use of the MS modifier, please refer to the Durable Medical Equipment Payment Policy and the Oxygen and Oxygen Equipment Payment Policy.

Modifier	Description
MS	Submit with HCPCS DME code to indicate six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty
NU	Submit with HCPCS DME code to indicate new durable medical equipment
RR	Submit with HCPCS DME code to indicate a rental
UE	Submit with HCPCS DME code to indicate used durable medical equipment

Level I CPT Modifiers

Modifier	Name	When to Use	Impact to Reimbursement
21	Prolonged evaluation and	When the service provided is prolonged or greater than that usually	

	management services	required for the highest level of evaluation and management service. If modifier 21 is used with low or moderate complexity evaluation and management services (99201, 99202, 99203, 99204), the claim will be rejected due to an invalid modifier/procedure combination.	
22	Increased procedural services	When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code... Note: This modifier should not be appended to an E/M service.	
24	Unrelated evaluation and management service by the same physician during a postoperative period	To indicate that an E/M service was performed during a postoperative period for a reason unrelated to the original procedure.	
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	To indicate that on the day a procedure identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service in addition to the other services provided or the preoperative and postoperative care associated with that procedure.	Reimbursement will be made for a preventive code with a problem focused code when modifier -25 is applied to the problem-focused code. Reimbursement for the preventive service will be made at 100% of the contracted rate, and reimbursement for the problem focused service will be made at 50% of the contracted rate. This should only occur when a significant abnormality or pre-existing condition is addressed and additional work is required to perform the key components of a problem focused E&M service and services should be submitted on the same claim.
26	Professional component	To indicate that the billed service is for the professional component for	

		radiology, pathology or cardiology. The acceptance of modifier 26 with a procedure is based on CMS guidelines.	
27	Multiple outpatient hospital E/M encounters on the same date	Report the use of hospital resources for separate E/M services: • provided to the same patient • by the same or different provider(s) • in more than one outpatient hospital setting • on the same date of service Modifier 27 is not allowed with radiology or laboratory procedures.	
32	Mandated services	To indicate services are related to mandated consultation and/or related services (e.g., third party payer, governmental, legislative or regulatory requirement)	
33	Preventive services	When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.	
50	Bilateral procedure	Surgical: To report bilateral procedures performed at the same operative session. Modifier 50 is used with surgical procedures (CPT-4 codes 10040–69990). Submit the procedure code on a single claim line with modifier 50 with 1 unit of service. Do not use this modifier to report surgical procedures already identified by their description as bilateral. Radiology: To report bilateral indicator 3 radiological services use modifier 50 and 1 unit of service or report on two claim lines with the RT and LT modifier and one unit on each line. Do not use the RT and LT modifier to report services already identified as bilateral by definition.	Reimbursement for bilateral services is determined by the Medicare Physician Fee Schedule Database (MPFSD).

51	Multiple procedures	When the same provider performs multiple procedures other than evaluation and management services at the same session, the primary procedure or service should be reported as listed. The additional procedure or service should be identified by adding the modifier 51 to its code. This modifier should not be appended to designated add-on codes.	An RVU will be assigned to each claim line based on the Medicare Physician Fee Schedule. Place of service (POS) is considered. If POS is office (11), the non-facility RVU is assigned, whereas, if POS is facility (e.g., 19, 21, 22, 24), then the facility RVU is assigned. The procedure code with the highest RVU will be reimbursed at 100% and the second and subsequent procedure(s) (third through fifth) will be reimbursed at 50%. Codes with no assigned RVU or an RVU of 0.00 will not be excluded from ranking. Codes with no assigned RVU or an an RVU value 0.00 and will be ranked as secondary or subsequent procedures when reported with other procedures that have an RVU value higher than 0.00. If multiple procedures with no assigned RVU or an RVU of 0.00 are billed on the same claim, the codes are ranked by billed charges.
52	Reduced services	To indicate that a service or procedure is partially reduced or eliminated at the physician's discretion. The reduced or eliminated procedure or service should be identified by adding the modifier –52 to its code.	Reimbursement for reduced surgical services will be at 50% of the billing physician's contracted rate.

		This modifier is also recognized for radiology services.	
53	Discontinued procedure	To indicate that the physician has elected to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.	Reimbursement will be reduced by 50% of the billing physician's contracted rate.
54	Surgical care only	When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding the modifier 54 to the usual procedure number.	Surgical only services will be reimbursed at 70% of the billing physician's contracted rate.
55	Postoperative	When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier –55 to the usual procedure number.	Postoperative management services will be reimbursed at 20% of the billing physician's contracted rate.
56	Preoperative	When one physician performs the preoperative care and evaluation management only and another physician performs the surgical procedure, the pre- operative component may be identified by adding the modifier 56 to the usual procedure number. Do not attach modifier 56 to an E/M code.	Preoperative management services will be reimbursed at 10% of the billing physician's contracted rate.
57	Decision for surgery	To indicate an evaluation and management service that resulted in the initial decision to perform surgery. CPT codes for use with the modifier 57 are 92002-92014 and 99201-99499. Use this modifier only in cases in which the decision for surgery was made during the preoperative period of a surgical procedure with a 90-day postoperative period (i.e., major surgery).	
58	Staged or related procedure or service by the same	To indicate that the performance of a procedure or service during the postoperative period was:	

	physician during the postoperative period	1. Prospectively planned with the original procedure (staged) 2. More extensive than the original procedure 3. For therapy following a diagnostic surgical procedure Note: This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.	
59	Distinct procedural service	To indicate that a procedure or service was distinct or independent from other services performed on the same day other than evaluation and management services. Modifier 59 is used to identify procedures/services that are not normally reported together but are appropriate under the circumstances. Use only if a more descriptive modifier is not available, and the use of modifier 59 best explains the circumstances. This modifier is also recognized for radiology services. Reimbursement for radiology services is not reduced.	The first procedure may be reimbursed at 100% of the billing physician's contracted rate. This modifier is also recognized for radiology services. Reimbursement for radiology services is not reduced.
62	Two surgeons	<u>Medicare and Community Care</u>: Modifer 62 is used when two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier 62. Co-surgeon also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Co-Surgeon Indicator in Medicare Physician Fee Schedule must be either 1 or 2. If surgeons of different specialties are each performing a different procedure (with specific CPT codes), co-surgeon rules do not apply (even if the procedures are performed through the same incision).	For Medicare and Community Care members, the addition of modifier 62 to an eligible procedure code allows payment of 62.5% of the Medicare Physician Fee Schedule effective for claims processed on or after March 1, 2024 (Medicare Claims Processing Manual, Chapter 12, 40.8. Claims for Co-Surgeons and Team Surgeons).
		<u>MassHealth</u>: When two eligible surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work	For MassHealth ACO members, the addition of modifier 62 to an eligible procedure code

		by adding the modifier 62 to the procedure code and any associated add-on code(s) for that procedure for as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) including add-on procedures, are performed during the same surgical session, separate code(s) may also be reported without the modifier 62 added.	allows payment of 57.5% of the allowable fee contained in 101 CMR 316.05(4)(b), adjusted by 101 CMR 316.03 as applicable, to each surgeon, effective for claims processed on or after March 1, 2024.
63	Procedure performed on infants less than 4 kg	Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance may be reported by adding the modifier 63 to the procedure code. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20000-69999 code series.	
66	Surgical team	When highly complex procedures requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, and various types of complex equipment are carried out under the surgical team concept.	Each physician will receive 62.5% of the billing physician's contracted rate.
73	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia	Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of the modifier 73. Note: The elective cancellation of a service prior to the administration of	Reimbursement will be reduced by 50% of the facility's contracted rate.

		anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.	
74	Discontinued out-patient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia	Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc.). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of the modifier 74. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.	
76	Repeat procedure	To indicate that a procedure or service was repeated subsequent to the original procedure or service by same physician. • This modifier is also recognized for radiology services.	
77	Repeat procedure by another physician	To indicate that a basic procedure or service performed by another physician had to be repeated. • This modifier is also recognized for radiology services. • The service is also used for Personal Care Attendants (see Personal Care Attendant Payment Policy for details)	
78	Return to the operating room for a related procedure during the postoperative period.	To indicate that another procedure was performed during the postoperative period of the initial procedure.	Reimbursement will be at 70% of the billing physician's contracted rate.
79	Unrelated procedure or service - postoperative period	To indicate that the performance of a procedure or service by the same physician during the post-operative	E/M services will not be reimbursed during postoperative period.

		period was unrelated to the original procedure.	
80	Assistant surgeon	To identify surgical assistant services, attach modifier to appropriate Surgical CPT-4 code.	1. Charges need to be submitted on a separate claim. 2. Automatic edits are utilized on assistant surgeon claims to determine clinical necessity of assistant surgeon for billed procedure. 3. The claim will be paid at 16% of the assistant surgeon's contracted rate.
81	Minimum Assistant Surgeon	Minimum surgical assistant services are identified by adding the modifier 81 to the usual procedure number. Use modifier 81 when the assistant-at-surgery is not present for the entire procedure.	1. Charges need to be submitted on a separate claim. 2. Automatic edits are utilized on assistant surgeon claims to determine clinical necessity of assistant surgeon for billed procedure. 3. The claim will be paid at 16% of the assistant surgeon's contracted rate.
82	Assistant surgeon when qualified resident surgeon not available	To identify the unavailability of a qualified resident surgeon, attach modifier to appropriate Surgical CPT-4 code.	1. Charges need to be submitted on a separate claim. 2. Automatic edits are utilized on assistant surgeon claims to determine clinical necessity of assistant surgeon for billed procedure. 3. The claim will be paid at 16% of the assistant surgeon's contracted rate.
91	Repeat Clinical Diagnostic Laboratory Test	In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its	

		usual procedure number and the addition of the modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.	
95	Synchronous Telemedicine Service Rendered Via a RealTime Interactive Audio and Video Telecommunications System	Please see Fallon Health's Telehealth Payment Policy for coverage.	

Level II HCPCS modifiers

Modifier	Name	When to Use	Impact to Reimbursement
AS	Physician assistant, nurse practitioner or clinical nurse specialist services for assistant-at-surgery	Use this modifier to indicate a physician assistant or nurse practitioner assisted at surgery.	1. Charges need to be submitted on a separate claim. 2. Automatic edits are utilized on assistant surgeon claims to determine clinical necessity of assistant surgeon for billed procedure. 3. The claim will be paid at 16% of the assistant surgeon's contracted rate.
CT	Computed tomography services furnished using equipment that does not meet each of the	Beginning in 2016, providers must submit this modifier with the following CPT codes[1] when the CT is furnished using equipment that does not meet the NEMA standards: 70450–70498	Beginning in 2016, a payment reduction of 5% applies to the technical component (and the technical component of the

[1] Medicare CT Modifier Reduction List, available at: https://www.cms.gov/medicare/physician-fee-schedule/ct-modifier-reduction-list.

	attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard	71250–71275 72125–72133 72191–72194 73200–73206 73700–73706 74150–74178 74261–74263 75571–75574	global fee) for CT services furnished using equipment that is inconsistent with the CT equipment standard and for which payment is made under the physician fee schedule. This payment reduction becomes 15% for 2017 and succeeding years.
Q5	Service performed by a substitute physician under a reciprocal billing arrangement	Use this modifier when services are furnished by a substitute physician under a reciprocal billing arrangement. This modifier has no effect on payment.	
Q6	Service furnished by a locum tenens physician	Use this modifier when services are furnished by a locum tenens physician. This modifier has no effect on payment.	
SA	Mid-Level practitioner rendering service in collaboration with a physician	Use this modifier when a nurse practitioner, physician assistant, or other mid-level practioner is rendering service in collaboration with a physician.	
SB	Nurse Midwife	Use this modifier to report professional services provided independently and use reduced service modifiers to report when they have not provided all the services covered by a global allowance. Ancillary services should not be reported with the SB modifier.	
SL	State supplied vaccine	Use this modifier to indicate the vaccine is state supplied.	The Plan does not reimburse for state supplied vaccines.
TC	Technical Component	Use to report only the technical component.	Payment is based solely on the technical value of each individual procedure.

Therapy Modifiers
Used to identify discipline of plan of care under which an outpatient therapy service is delivered.

Modifier	Description
GN	Services delivered under an outpatient speech language pathology plan of care
GO	Services delivered under an outpatient occupational therapy plan of care

GP	Services delivered under an outpatient physical therapy plan of care

Therapy Assistant Modifiers
Used to identify services delivered in whole or in part by PTAs and OTAs on and after January 1, 2020 for Medicare members. The therapy assistant modifiers must be reported alongside the respective GP or GO modifier. The services of PTAs and OTAs may not be billed incident to the services of physicians or NPPs, because PTAs/OTAs do not meet the qualifications of a therapist. See Physical and Occupational Therapy Payment Policy for additional information.

Modifier	Description
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

Billing/coding guidelines

Modifier KX
The KX modifier is a multipurpose, informational modifier and can be used to identify services for transgender, ambiguous genitalia, and hermaphrodite beneficiaries in addition to its other existing uses. Physicians and non-physician practitioners should use modifier KX with procedure codes that are gender specific in the particular cases of transgender, ambiguous genitalia, and hermaphrodite beneficiaries.

Modifier 22
Examples of when Modifier 22 may be appropriate:

- Excessive blood loss for the particular procedure performed
- Extensive, well-documented adhesions present with an abdominal surgery and requiring a minimum of 45 minutes to lyse.
- Presence of an excessively large surgical specimen (tumor).
- Trauma so extensive that the particular procedure and complication is not billed as separate and distinct procedures themselves.
- Other pathologies, tumors, and malformations that increase the complexity of the procedure.
- Extended anesthesia is identified (anesthesia record must be submitted).

Do not submit modifier 22 if you are reporting any of the following:

- Increased complexity due to a surgeon’s choice of approach.
- Describing a re-operation.
- Describing a weight reduction surgery.
- Describing the use of robotic assistance.
- An unspecified procedure code.

Modifier 25
The American Medical Association’s CPT Coding Manual describes the use of modifier 25 as “the physician may need to indicate that on the day that a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed”.

Modifier 33
The Plan accepts and recognizes the use of modifier 33 when billed with services on the U.S. Preventive Services Task Force List that have an A or B rating.

The American Medical Association created this modifier to allow providers to identify a preventive service for which patient cost sharing does not apply under the Patient Protection and Affordable Care Act, which prohibits patient cost sharing for non-grandfathered plans.

Modifier 33 is appropriate to use with a CPT code that is a diagnostic/treatment service being performed as a preventive service. This modifier has no impact on claims payment.

Modifier 50

The National Correct Coding Initiative (NCCI) manual specifies that modifier -50 is used to report bilateral surgical procedures as a single unit of service. Coding claims for procedures perfomed bilaterally depends on the code descriptor and the bilateral surgery indicator assigned to the code.

Bilateral Surgery Indicators

- Indicator 0 - Bilateral surgery rules do not apply. This procedure code that cannot be billed bilaterally. An example is CPT 11100, Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion.
- Indicator 1 - Bilateral surgery rules apply (150% payment adjustment). Report procedures performed bilaterally on one claim line with modifier 50 and 1 unit of service.
- Indicator 2 - Bilateral surgery rules do not apply. These codes are inherently bilateral. Code description may include terms like “bilateral” or “unilateral or bilateral”.
- Indicator 3 - Bilateral surgery rules do not apply. Services in this category are generally radiology procedures or other diagnostic tests.
- Indicator 9 - Bilateral surgery concept does not apply (office visit).

Bilateral indicator 3

Bilateral indicator 3 codes are not subject to the 150% bilateral adjustment applied to Indicator 1 codes. Instead, bilateral services will be reimbursed at 200% of the applicable fee schedule rate (100% for right side and 100% for left side), less any applicable multiple procedure pricing reductions.

Bilateral services for codes with a bilateral indicator of 3 may be reported in one of the following methods:

- On one claim line with modifier 50 and 1 unit of service, or
- On two separate claim lines with 1 unit of service each, one with modifier RT appended and one with modifier LT appended, or
- On one claim line with 2 units of service and modifier RT and LT appended.

Procedure codes with a bilateral indicator of 3 may not be reported with modifier 50 on a single line with two units of service or on two separate lines with 1 unit of service,

Modifier 59 and subsets

Modifier 59 subsets: CMS has established four new HCPCS modifiers (XE, XS, XP, XU) to define subsets of modifier 59, used to define a “Distinct Procedural Service”. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible.

The Plan accepts either a modifier 59 or a more selective modifier as correct coding, and the compensation impact currently applied to modifier 59 will be applied to modifiers XE, XP, XS, and XU. Professional claims submitted with modifier 59 (or XE, XS, XP, XU as appropriate) will deny upon initial submission. A Provider Appeal must be submitted with supporting medical records for payment consideration.

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	07/01/2016
Previous revision date(s):	N/A
Connection date & details:	September 2016 – Introduced policy. January 2018 – Annual Review, no updates. April 2018 – Clarified reimbursement of AS modifier. October 2018 – Removed pre-claim adjudication operative note review for all modifiers. October 2019 – Updated modifier tables. April 2020 – Updated modifier tables. July 2021 – Removed references to Provider Manual throughout; under Reimbursement, added Therapy Assistant Modifiers, deleted Therapy Function Modifiers; added clairification under Modifier 59 and subsets in the Billing/coding guidelines section. January 2022 – Updated to include Level II HCPCS modifier CT. July 2022 – Updated to include Billing/coding information for modifier 50. January 2024 – Updated information on modifier 62 in Level 1 CPT Modifier Table. October 2024 – Under Reimbursement, in the Level I CPT Modifiers table, for Modifier 51, clarified that codes with no assigned RVU or an RVU of 0.00 will not be excluded from ranking. Codes with no assigned RVU or an an RVU value 0.00 and will be ranked as secondary or subsequent procedures when reported with other procedures that have an RVU value higher than 0.00. If multiple procedures with no assigned RVU or an RVU of 0.00 are billed on the same claim, the codes are ranked by billed charges. July 2025 – Under Reimbursement, clarified use of Advance Beneficiary Notice of Noncoverage (ABN) Modifiers.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.