Product Information

UCare's products include Commercial, Medicare, and Minnesota Health Care Programs (MHCP). For detailed information regarding the Plans covered under these products refer to UCare's website under Health Plans.

General Payment Information

The information provided below outlines the impact appending a specific modifier will have on payment of professional claims. Payment for each eligible professional service is based on the lesser of charge, or the increase, decrease or change in payment that is specific to the modifier that has been appended to the service.

Modifiers

Modifiers are used as means to communicate that a service or procedure has been altered by some specific circumstance without changing the description of the service provided, communicate additional information regarding the provider performing the service, provide clarity regarding the service performed, or to meet specific payment policy requirements. Outlined below is general information regarding the use of modifiers and the impact the use of those modifiers may have on payment.

ANETHESIA MODIFIERS		
Refer to UCare's Anesthesia Policies for detailed information the use of and payment associated with the use of anesthesia modifiers.		
MODIFIER	**NARRATIVE DESCRIPTION**	**LINKS TO PERTINENT INFORMATION**
AA	Anesthesia services performed personally by anesthesiologist.	CMS (IOM), Publication 100-4, Medicare Claims Processing Manual, Chapter 12, Section 50 CMS.gov anesthesiologists center Medicaid/MHCP Provider Manual, Anesthesia UCare Medicare Anesthesia Policy UCare MHCP Anesthesia Policy
AD	Medical supervision by a physician: more than 4 concurrent anesthesia procedures	
GC	Services performed in part by a resident under the direction of a teaching physician.	
G8	Monitored anesthesia care (MAC) for deep complex complicated, or markedly invasive surgical procedures.	
G9	Monitored anesthesia care (MAV) for a patient who has a history of severe cardiopulmonary condition.	
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals.	
QS	Monitored anesthesia care (MAC) services	
QX	Qualified non-physician anesthetist with medical direction by a physician.	
QY	Medical direction of one qualified non-physician anesthetist by an anesthesiologist.	
QZ	CRNA without medical direction by a physician.	

PHYSICAL STATUS MODIFIERS		
Physical Status Modifiers provide additional information regarding the overall physical status of the patient, identifying various levels of complexity impacting the patient and the administration of anesthesia. Medicare considers these modifiers to be informational and does not provide any additional payment when any of these modifiers are appended to anesthesia services.		
MODIFIER	**NARRATIVE DESCRIPTION**	**LINKS TO PERTINENT INFORMATION**
P1	A normal healthy patient.	CMS (IOM), Publication 100-4, Medicare Claims Processing Manual, Chapter 12, Section 50 CMS.gov anesthesiologists center Medicaid/MHCP Provider Manual Anesthesia Services
P2	A patient with mild systemic disease.	
P3	A patient with severe systemic disease.	
P4	A patient with severe systemic disease that is a constant threat to life.	
P5	A moribund patient who is not expected to survive without the operation.	
P6	A declared brain-dead patient whose organs are being removed for donor purposes.	

Distinct Procedural Service and X-(EPSU) Modifiers		
MODIFIER	**NARRATIVE DESCRIPTION**	**LINKS TO PERTINENT INFORMATION**
59	Distinct Procedural Service	CMS IOM, Publication 100-09, Medicare Contractor Beneficiary and Provider Manual, Chapter 5, Section 20.4 MLN Matters, Special Edition SE1418 National Correct Coding Edits (NCCI) MMM 8863 MM Special Edition 1503
XE	Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter	
XP	Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner.	
XS	Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner.	
XU	Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.	

The modifier listed below are specific to mental health services eligible for coverage under one of UCare's State Public Programs or dual eligible products. Refer to UCare's Mental Health Policies for detailed information regarding the services requiring a modifier(s) and the correct use of each modifier associated with the service.

MODIFIER	NARRATIVE DESCRIPTION	LINKS TO PERTINENT INFORMATION
AG	Primary Care Provider Receiving Psychiatric Consultation	MHCP Modifiers
AM	Consulting Psychiatrist to primary care provider	
HA	Child or Adolescent	
HE	Mental Health	
HK	Intensive or Children's Day Treatment	
HM	Adult MH Rehabilitation Worker or Mental Health Behavioral Aide Level II	
HN	Qualified Mental Health Practitioner or Bachelor Degree Level (Clinical Trainee)	
HQ	Group Modality	
HR	Family/Couple with Client Present	
HS	Family/Couple without Client Present	
TG	Extended Diagnostic Update/Psychiatric Consultation complex/lengthy	
TS	Adult Diagnostic Update	
UA	CTSS service package/Children's crisis service package	
UB	Children's Clinical Care Consultation - 21 to 30 minutes	
UC	Children's Clinical Care Consultation - 31 minutes and above	
UD	MH Assessment, Physician Administered Claims	
U1	Dialectical Behavior Therapy (DBT)	
U3	ARMHS Transitioning to community living	
U4	Service provided via non face-to-face contact, e.g., telephone	
U5	Certified Peer Specialist Level I	
U6	Interactive Behavioral Health Day Treatment	
U8	Child Children's Clinical Care Consultation - 11 to 20 minutes Children's Clinical Care Consultation - 5 to 10 minutes	
U9	Children's Clinical Care Consultation - 11 to 20 minutes	
52	Brief Diagnostic Assessment	

EVALUATION AND MANAAGEMENT MODIFIERS (E/M)		
MODIFIER	**NARRATIVE DESCRIPTION**	**LINKS TO PERTINENT INFORMATION**
24	Unrelated Evaluation and Management (E&M) Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period The -24 modifier should be appended to an E&M service or eye exam performed within the global period of a major (90 days) or minor surgery (10 days) performed by a surgeon to indicate that the E&M service is unrelated to the surgery. It is not necessary to submit supporting documentation with the claim. However, UCare reserves the right to request supporting documentation that indicates the E&M service is unrelated to the surgery. Supporting documentation must be made available upon request.	Medicare Learning Network (MLN) Matters Global Surgery Fact Booklet CMS Internet Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Sections 30.6.6 and 40.2 Medicaid/MHCP Provider Manual, Physician and Professional Services
25	Significant, Separately Identifiable Evaluation and Management (E&M) Service by the Same Physician or Other Qualified Health Care Professional on the Same Day the Procedure or Other Service The -25 modifier should be appended to a service to indicate that on the day a procedure or service was performed the patient's condition required a significant, separately identifiable E&M service above and beyond other service provided. It is not necessary to submit supporting documentation with the claim. However, UCare reserves the right to request documentation to support that the E&M service is unrelated to surgery. Supporting documentation must be made available upon request.	
57	Decision for Surgery	

SURGICAL MODIFIERS		
MODIFIER	NARRATIVE DESCRIPTION	LINKS TO PERTINENT INFORMATION
22	Increased Procedural Services This should only be used when documentation indicates work performed is substantially greater than typically required by technical difficulty, severity of patient's condition or increased intensity and time.	CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 20.4.6 and 40.2
50	Bilateral Procedure. The -50 modifier must be appended to diagnostic and radiology procedures and surgical procedures. Report bilateral procedures that are performed at same operative session as a single line item. Modifiers RT and LT are not used when modifier 50 applies. A bilateral procedure is reported on a single claim line.	CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 40.7 Medicare Claims Processing Manual, Chapter 23 – Fee Schedule Administration and Coding Requirements, Section 50.6 Medicaid/MHCP Provider Manual, Physician and Professional Services, Surgical Services
51	Multiple Procedures This modifier is informational. When multiple procedures are performed on the same day, claim payment will be determined based on the allowed amount for each procedure. The highest valued procedure will be paid as primary and the remaining procedures will be paid as secondary procedures.	CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 40.6 Medicare Learning Network (MLN) Matters Global Surgery Booklet Medicaid/MHCP Provider Manual, Physician and Professional Services, Surgical Services
52	Reduced Services	CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Sections 20.4.6, 30.6.1, 40.2, and 40.4
53	Discontinued Procedure	CMS IOM, Publication 100-04, Medicare Claims

SURGICAL MODIFIERS		
MODIFIER	**NARRATIVE DESCRIPTION**	**LINKS TO PERTINENT INFORMATION**
		Processing Manual, Chapter 12, Section 30.1 MM9317
54	Surgical Care Only	CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 40 Medicare Learning Network (MLN) Matters Global Surgery Booklet
55	Postoperative Management Only	
56	Preoperative Management Only	
58	Stage or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period The -58 modifier indicates the procedure(s) performed during the postoperative period of another surgical procedure when subsequent procedure(s) was planned prospectively at time of original procedure, a less extensive procedure fails and a more extensive procedure is required or a therapeutic surgical procedure follows a diagnostic procedure.	CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 40.2 Medicare Claims Processing Manual Chapter 4, Section 20.6 Medicare Learning Network (MLN) Matters Global Surgery Booklet
62	Two Surgeons The MPFSDB professional fee schedule includes an Indicator Co-Surgeon (Two surgeons) (CO-SURG). Indicator 1 and 2 identifies services which must be sufficiently documented to establish that a co-surgeon was medically necessary. The base allowed amount for eligible co-surgeon payment is 62.5% of UCare's global surgery fee schedule amount.	CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 40.8 Medicare Learning Network (MLN) Matters Global Surgery Booklet
63	Procedure Performed on an Infant Less Than 4kg	
66	Surgical Team HCPCS/CPT© codes on the MPFSDB professional fee schedule with a Team Surgery Indicator (TEAM SURG) of 1 and 2 may be eligible for team surgery reimbursement. Each surgeon should submit a claim and an operative report and any other supporting documentation for the	CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 40.8

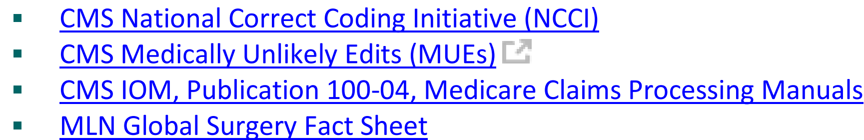
SURGICAL MODIFIERS		
MODIFIER	**NARRATIVE DESCRIPTION**	**LINKS TO PERTINENT INFORMATION**
	surgery performed. Modifier -66 should be appended to each HCPCS/CPT© code submitted. Team surgeons should submit the same HCPCS/CPT© codes. Payment will be determined based on review of the documentation submitted. Claims submitted without documentation will be denied. When multiple surgical procedures are performed, multiple surgery guidelines do apply.	Medicare Learning Network (MLN) Matters Global Surgery Booklet
78	Unplanned Return to the Operating / Procedure Room by the Same Physician or Other Qualified Health Care Professional Following the Initial Procedure During the Postoperative Period.	CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 40.2, 40.8 Medicare Learning Network (MLN) Matters Global Surgery Booklet
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period Append the -79 modifier to indicate that a procedure or service furnished during a postoperative period was unrelated to the original procedure. A new post-operative period begins when unrelated procedure is billed.	Medicare Claims Processing Manual, Chapter 12, Sections 30 and 40.2 Medicare Learning Network (MLN) Matters Global Surgery Booklet
80	Assistant Surgeon	CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 20.4.3 Medicaid/MHCP Provider Manual, Physician and Professional Services, Surgical Services, Assistant at Surgery Medicare Learning Network (MLN) Matters Global Surgery Booklet
81	Minimal Assistant Surgeon	
82	Assistant Surgeon (when a qualified resident surgeon not available)	
AS	Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assist at surgery.	

OFF CAMPUS AND PROVIDER-BASED DEPARTMENT OF A HOSPITAL		
MODIFIER	NARRATIVE DESCRIPTION	LINKS TO PERTINENT INFORMATION
PN	Non-Exempted Off-Campus Provider Based Departments	
PO	Services, Procedures and/or Surgeries Furnished at Off-Campus Provider-Based Department of Hospital	

340B DRUG PRICING PROGRAM MODIFIERS		
MODIFIER	NARRATIVE DESCRIPTION	LINKS TO PERTINENT INFORMATION
JG	Drug or Biological Acquired With 340B Drug Pricing Program Discount Modifier	
TB	Drug or Biological Acquired With 340B Drug Pricing Program Discount, Reported for Informational Purposes	
UD	Drug or Biological Drug Acquired with 340B Discount	

Additional Resources

Medicare



- CMS National Correct Coding Initiative (NCCI)
- CMS Medically Unlikely Edits (MUEs)
- CMS IOM, Publication 100-04, Medicare Claims Processing Manuals
- MLN Global Surgery Fact Sheet

Medicaid / MHCP

- MHCP Provider Manual

Disclaimer

The following disclaimer applies to the modifier grid published by UCare and all of the UCare's published attachments provided therein.

The examples provided above are for illustrative purposes only, and are not intended to be a guarantee of coverage or payment.

Payment policies assist in administering payment for UCare benefits under UCare's health plans. Payment policies are intended to serve only as a general reference resource regarding UCare's administration of health benefits and are not intended to address all issues related to payment for health care services provided to UCare members. In particular, when submitting claims, all providers must first identify member eligibility, federal and state legislation or regulatory guidance regarding claim submission, UCare provider participation agreement contract terms, and member specific Evidence of Coverage (EOC) or other benefit documents. In the event of a conflict, these sources supersede the Payment Policies. Payment Policies are provided for informational purposes and do not constitute coding or compliance advice. Providers are responsible for submission of accurate and compliant claims. In addition to Payment Policies, UCare also uses tools developed by third parties, such as the Current Procedural Terminology (CPT®), InterQual guidelines, Centers for Medicare and Medicaid Services (CMS), the Minnesota Department of Human Services (DHS), or other coding guidelines, to assist in administering health benefits. References to CPT© or other sources in UCare Payment Policies are for definitional purposes only and do not imply any right to payment. Other UCare Policies and Coverage Determination Guidelines may also apply. UCare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary and to administer payments in a manner other than as described by UCare Payment Policies when necessitated by operational considerations."*

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