KAISER PERMANENTE®

PAYMENT POLICY

MODIFIERS

Scope

This policy applies to:

☒ Kaiser Permanente Health Plan of Washington

☒ Kaiser Permanente Health Plan of Washington Options, Inc.

☒ Commercial

☒ Medicare

☐ Medicaid

Policy

Original Effective Date: 09/01/2014

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) will review the presence or absence of modifiers coded on all claim types. A modifier should be appended to provide additional information about the service rendered. Addition of a modifier may impact the claim reimbursement amount. Listed below are some of the more common modifiers. The inclusion of a modifier does not guarantee reimbursement.

Modifier	Description	Reimbursement
22	Unusual procedural services	Eligible for increased reimbursement at 125% of the allowable when the Centers for Medicare & Medicaid Services (CMS) global day indicator is 000, 010, 090, or MMM. Clinical records will be required.
24	Unrelated Evaluation and Management (E/M) service by the same physician or other qualified health care professional during a postoperative period	Modifier will not impact reimbursement amount.
25	Significant, separately identifiable E&M service by the same physician on the same day of the procedure or other service	Modifier will not impact reimbursement amount.
26	Professional Component	Reimbursement is at the modified amount per the applicable fee schedule. A Professional Component will not be reimbursed when a diagnostic laboratory service is provided either manually or with automated equipment, as these codes are not subject to the Professional Component/Technical Component (PC/TC) concept or are Technical Component only codes.

		Kaiser Permanente follows CMS PC/TC indicators in determining which services do not qualify for Professional Component reimbursement: • CMS PC/TC Indicator 3 (Technical Component only codes) • CMS PC/TC Indicator 9 (PC/TC Concept not applicable)
50	Bilateral procedure	Eligible for increased reimbursement at 150% of the allowable when CMS bilateral procedure indicator is one (1). Claims billed with CMS bilateral indicators of zero (0), two (2) or nine (9) will be denied.
51	Multiple procedures	Primary procedure is reimbursed at 100% of the allowable. Additional procedures are reimbursed at 50% of the allowable when CMS multiple procedure indicator is a two, three, or five, 75% of the allowable when CMS multiple procedure indicator is a six, or 80% of the allowable when CMS multiple procedure indicator is a seven.
52	Reduced procedures	Reimbursement is at 75% of the allowable.
53	Discontinued procedures	Reimbursement is at 50% of the allowable.
54	Surgical care only	Reimbursement is at the CMS Preoperative % indicator plus the Intraoperative % indicator amount multiplied by the allowable. Professional surgical services in place of service 23 (emergency room) will not be reimbursed when billed without Modifier 54.
55	Post-operative management only	Reimbursement is at the CMS Postoperative % indicator amount multiplied by the allowable
56	Pre-operative management only	Reimbursement is at the CMS Preoperative % indicator amount multiplied by the allowable.
57	Decision for surgery	Reimbursement is allowed when the surgical procedure performed on the same day or the day after has a CMS global indicator of 090, MMM, or XXX. E/M codes billed with Modifier 57 the day before or the day of a surgical procedure with a global period of 000 or 010 will not be reimbursed.

		E/M codes billed with Modifier 57 with no surgical procedure billed the day of or day after the E/M service will not be reimbursed.
59	Distinct procedural service	Eligible for payment to the extent the service is not considered bundled based on NCCI coding guidelines. Does not apply to Evaluation and Management (E/M) Services
62	Two surgeons	Reimbursement is at 62.5% of the allowable when the CMS Co-surgeon indicator is a one or two.
63	Procedure performed on infants less than 4kg	Eligible for increased reimbursement at 125% of the allowable when the CMS global day indicator is 000, 010, 090, or MMM. Clinical records will be required.
66	Surgical team	Reimbursement is at 80% of the allowable when the CMS team surgeon indicator is a one or two for commercial members. Reimbursement is at 70% of the allowable when the CMS team surgeon indicator is a one or two for Medicare members.
73	Discontinued outpatient hospital ASC procedure prior to the administration of anesthesia	Reimbursement is at 50% of the allowable amount.
74	Discontinued outpatient facility ASC procedure after the administration of anesthesia	Reimbursement is at 100% of the allowable amount.
76	Repeat procedure or service by same physician or other qualified health care professional	Modifier will not impact reimbursement amount.
77	Repeat procedure by another physician or other qualified health care professional	Modifier will not impact reimbursement amount.
78	Return to the operating room for a related procedure during the post-operative period	Reimbursement is at the CMS intraoperative % indicator amount multiplied by the allowable amount.
79	Unrelated procedure or service by the same physician during the post-operative period	Modifier will not impact reimbursement amount.
80	Assistant surgeon	See Assistant Surgeon policy.
81	Minimum assistant surgeon	See Assistant Surgeon policy.
82	Assistant surgeon	See Assistant Surgeon policy.
90	Inappropriate use	Laboratory claims billed with Modifier 90 will be denied when submitted by a provider other than an independent lab. See Laboratory policy.

	Duplicate use	Laboratory claims will be denied when the claim has already been paid and a second claim for the same procedure by the same or different provider on the same date of service with or without Modifier 90 is received. See Laboratory policy.
91	Repeat clinical diagnostic laboratory tests	Append modifier to report repeat clinical diagnostic lab tests or studies performed on the same day on the same member to obtain subsequent test results. Should not be submitted when a test is rerun to confirm the initial results due to an issue with the specimen, equipment or for any other reason when the one-time reportable result was all that was required.
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System	Modifier will not impact reimbursement amount.
AA	Anesthesia services performed personally by anesthesiologist	Reimbursement is at 100% of the allowable amount.
AD	Medical supervision by a physician, more than 4 concurrent anesthesia procedures	Reimbursement is at 50% of the allowable amount.
AS	Assistant surgeon	See Assistant Surgeon policy.
FQ	The service was furnished using audio-only communication technology	Modifier will not impact reimbursement amount.
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals	Reimbursement is at 50% of the allowable amount.
QX	CRNA service with medical direction for anesthesia by a physician	Reimbursement is at 50% of the allowable amount.
QY	Medical direction of one CRNA by anesthesiologist	Reimbursement is at 50% of the allowable amount.
SA	Used when an Advanced Practice Health Care Provider, who does not have their own NPI, assists the provider in a procedure other than a surgery	**Effective 11/01/24**, reimbursement is at 85% of the supervising physicians fee schedule
SS	Home infusion services provided in the infusion suite of the IV therapy provider	Modifier will not impact reimbursement amount. Modifier will impact member cost shares.
TC	Technical component	Reimbursement is at the modified amount per the applicable fee schedule.

XE	Separate encounter: documentation must support the service is distinct because it occurred during a separate encounter.	Eligible for payment to the extent the service is not considered bundled based on NCCI coding guidelines. Does not apply to Evaluation and Management (E/M) Services
XP	Separate encounter: documentation must support the service is distinct because it was performed by a different practitioner.	Eligible for payment to the extent the service is not considered bundled based on NCCI coding guidelines. Does not apply to Evaluation and Management (E/M) Services
XS	Separate Structure: documentation must support the service is distinct because it was performed on a separate organ/structure.	Eligible for payment to the extent the service is not considered bundled based on NCCI coding guidelines. Does not apply to Evaluation and Management (E/M) Services
XU	Unusual non-overlapping service: documentation must support the use of a service is distinct because it does not overlap usual components of the main service.	Eligible for payment to the extent the service is not considered bundled based on NCCI coding guidelines. Does not apply to Evaluation and Management (E/M) Services

**All services are subject to code editing.

Billing/Coding Guidelines

All claims must be billed according to Centers for Medicare & Medicaid Services (CMS) guidelines.

Claims should be submitted with the correct modifier-to-procedure code combination.

Policy Definitions

Noridian Modifier 54 - Surgical Care Only. When a physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding this modifier to the usual procedure code.

Modifier 93 – Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system.

Modifier FQ – The service was furnished using audio-only communication technology.

Prerequisite(s)

Not applicable

References

CPT® Appendix T audio only Modifier 93 for reporting medical services, AMA

List of Telehealth Services, CMS

Medicare Claims Processing Manual: Chapter 23 – Fee Schedule Administration and Coding Requirements

Physician Fee Schedule Relative Value Files, CMS

Proper Use of Modifiers 59 & - X{EPSU} – MLN Fact Sheet; March 2022

Code Editing – Kaiser Permanente payment policy

Advanced Practice Registered Nurses (APRNs), CMS

Advanced Practice Health Care Providers – Kaiser Permanente Payment Policy

Frequently Asked Questions

Q1: A member had a minor surgery and was given anesthesia. Will the anesthesia services be reimbursed when coded with a QX modifier?

A1: Yes. Kaiser Permanente reimburses anesthesia at 50% of the allowable amount when coded with a QX modifier.

Q2: A member had infusion services provided in the ambulatory infusion suite. Should services be billed with modifier SS in addition to 11/49 place of service?

A2: Yes, infusion services provided in the infusion suite should be billed with modifier SS on all lines.

Revision History

05/21/2024 – Added modifiers QZ and SA

02/28/2023 – Added new payment instructions for modifier 50

Added modifiers 24, 91, XE, XP, XS, XU

Added additional reference links

12/06/2022 – Added instructions for modifier 90

08/30/2022 – Added professional/technical component (PC/TC) language for modifier 26

04/20/2022 – Corrected last revision date.

02/01/2022 – Addition of modifiers 93 and FQ for audio-only telemedicine claims

12/14/2021 – Updated modifier 54 and 57

08/26/2021 – Added SS modifier

09/01/2014 – New Policy

Note: This information is intended to serve only as a general reference resource regarding reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, we may use reasonable discretion in interpreting and applying this policy to services being delivered in a particular case. Further, the policy does not cover all issues related to reimbursement for services rendered to our enrollees as legislative mandates, the provider contracts, the enrollee's benefit coverage documents, and the Provider Manual all may supplement or in some cases supersede this policy. This policy may be modified from time to time by publishing a new version of the policy on Kaiser Permanente provider website; however, the information presented in this policy is believed to be accurate and current as of the date of publication.