Billing and Reimbursement

Appropriate modifier usage

Geisinger Health Plan

HCPCS Level II “J” and “Q” code modifier guidelines

- “J” and “Q” codes are used to report drugs that ordinarily cannot be self-administered. It is not appropriate to add anatomical site modifiers to these services.

Modifier – a two-character code that indicates a service or a procedure has been altered by some specific circumstance but has not changed in its definition or code (CPT guidelines)

Global vs. -TC and -26 modifiers guidelines

- Providers should not use the –TC modifier with procedure codes that already describe and represent only the technical component.
- Likewise, providers should not use the -26 modifier with procedure codes that already describe and represent only the professional component.
- Inappropriate reporting, such as listed above, will result in a denial for an invalid procedure code/modifier combination.

Modifier -25 guidelines

- Modifier -25 is used to report a significant separately identifiable evaluation and management (E&M) service that was performed by the same physician on the same day of the procedure or other service.
- Modifier -25 may be reported with an E&M code on the day a procedural service was performed, and the physician indicates the member’s condition required a significantly separately identifiable service from the procedure(s) performed that day or the E&M was above and beyond the usual pre-procedure or post-procedure case that is associated with the procedure(s) performed.
- The E&M service may be prompted by the condition or symptom for which the procedure was provided.
- Different diagnoses are not required for reporting the E&M on the same date as the procedure.
- Medical documentation may be required to support payment when reporting an E&M service with a modifier -25 and a procedure on the same date of service when the diagnosis codes reported are the same or related. Providers are encouraged to submit paper claims with supporting medical documentation attached.
- If medical documentation does not support the criteria listed in the second bullet point or is insufficient to support the E&M level of service, the E&M service will be denied.

- If the E&M service is denied, a member's office visit copayment is not applicable.
- GHP conducts retrospective audits, which may include E&M services reported with modifier-25 on the same day as a procedure when the diagnosis codes are distinct or unrelated.

Modifier -50 guidelines

- Modifier -50 should be used with the appropriate CPT® code to indicate bilateral procedures performed during the same operative session.
- The unit reported in field 24G on the CMS 1500 claim form should equal one.
- GHP reimbursement for bilateral procedures is calculated using 150% of GHP payment schedule amount, except as otherwise noted in correct coding rules and taking into consideration any multiple surgery reduction adjustments.

Modifier -59, XE, XP, XS, and XU guidelines

- As the most commonly used health care common procedure coding system (HCPCS) modifier, modifier -59 is used to indicate that a code is separate and distinct from another service with which it is typically considered bundled. The Centers for Medicare and Medicaid Services (CMS) has created four additional HCPCS modifiers to better define subsets of the -59 modifier designed to reduce modifier -59 usage and improve claims processing for providers. The following modifiers should be used in its place when appropriate:
    - XP – Separate practitioner; a service that is distinct because it was performed by a different provider
    - XS – Separate structure; a service that is distinct because it was performed on a separate organ/structure
    - XU – Unusual non-overlapping service; the use of a service that is distinct because it does not overlap usual components of the main service
    - XE – Separate encounter; a service that is distinct because it occurred during a separate encounter
- Providers can continue to use modifier -59, but only when a more descriptive modifier is not appropriate.
- Supporting medical documentation is only required for modifier -59 and the XU modifier.
- GHP reserves the right to retrospectively review services reported with the X{EPSU} modifiers.

Publication history: