September 1, 2017

Provider Memorandum

Valid Modifier to Procedure Code Combinations

Molina Healthcare of Illinois (Molina) follows Illinois Department of Healthcare and Family Services (HFS) guidelines for claims processing and payment for the Covered Families and Children (CFC) and Aged, Blind or Disabled (ABD) programs, populations covered under Molina's Integrated Care Program and Family Health Plan programs.

This provider communications provides a guide for the use of the appropriate modifiers for covered medical services, surgical services and supplies.

The Molina code editing system is able to identify a specific list of modifiers that are appropriate to be billed with each five-digit procedure code. Although the procedure code is a valid procedure code and the modifier is a valid modifier, if the procedure and modifier combination is not appropriate to be used together, the line item will deny as an invalid modifier combination. These edits are currently applied to claims billed on CMS1500 claim form and or on UB04/CMS1450.

Please note, not all possible modifier combinations can be covered in this document. The following is offered to help address the most common questions and concerns submitted to Molina regarding invalid modifier combination denials.

Modifier-specific guidelines

- Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance, but has not been changed in definition or code.
- Modifiers are intended to communicate specific information about a certain provider type, service or procedure that is not already contained in the code definition itself. Some examples are:
    - To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery;
    - To indicate that a procedure was performed bilaterally;
    - To report multiple procedures performed at the same session by the same provider;
    - To report only the professional component or only the technical component of a procedure or service;
    - To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourt digit); and
    - To indicate special ambulance circumstances
- More than one modifier can be attached to a procedure code when applicable.Not all modifiers can be used with all procedure codes.
- Modifiers do not ensure reimbursement.Some modifiers increase or decrease reimbursement and others are only informational.
- Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code.

Resolving modifier denials

- If a line item is denied for an invalid modifier combination, a correct claims must be submitted along with the Member's medical records. Please note claims cannot be adjusted based upon a phone call to Member Services.
- If you believe the invalid modifier denial is incorrect, please submit a written provider appeal and include HFS billing guidelines supporting why the procedure code and modifier combination should be reconsidered.

Modifier examples

Modifier(s)	Reimbursement Guidelines	Examples of combinations which willdeny for invalid modifier combination
24, 25	Modifiers 24 and 25 are valid on Evaluation and Management (E/M) procedure codes only.	Do not use modifiers 24 and 25 with surgical codes, medicine procedures, diagnostic tests and procedures, etc.
26	Modifier 26 is considered valid for procedures with a Professional Component (PC)/Technical Component (TC) Indicator of 1 or 6.	Do not use modifier 26 for procedures with a Professional Component (PC)/Technical Component (TC) Indicator of 0, 2, 3, 4, 5, 7, or 9.
TC	Modifier TC is considered valid for procedures with a Professional Component (PC)/Technical Component (TC) Indicator of 1.	Do not use modifier TC for procedures with a Professional Component (PC)/Technical Component (TC) Indicator of 0, 2, 3, 4, 5, 7, 8, or 9.
50	Modifier 50 is considered valid on codes that have a bilateral indicator of 1.	Do not use modifier 50 with procedurecodes that have a bilateral indicator of 0, 2, 3, or 9 on the Physician Fee Schedule; another modifier should be used or the code is already priced as bilateral.
51	Modifier 51 is considered valid for procedures with a multiple procedure indicator of 2, 3, 4, 5, 6, or 7.	The CMS Physician Fee Schedule indicates that modifier 51 is not eligible to be used with the CMT codes (98940 -98943). Molina will deny 98940 - 98943 for invalid modifier combination when billed with modifier 51.
52	Modifier 52 (reduced services) signifies that only part of the code description was performed, some parts were omitted.	Do not use modifier 52 with: • Evaluation and management codes. •When another code is available to describe a lesser service. •With an all-or-nothing procedure code. • With an unlisted code.

Modifier(s)	Reimbursement Guidelines	Examples of combinations which will deny for invalid modifier combination
90	Modifier 90 = Reference (outside) laboratory Valid for laboratory test procedures. By definition, modifier 90 indicates the services described by the procedure code billed with modifier 90 attached were **NOT** performed by the physician or office submitting the claim.	36415-90 will be denied for invalid modifier combination. A drawing fee or venipuncture cannot be referenced out to another lab so modifier 90 should not be reported with CPT code 36415. If the office performs venipuncture (36415) to send the specimen to an outside laboratory for tests, then they have performed the venipuncture, and it is not correct to attach modifier 90 to 36415.
LT, RT	Modifiers LT and RT are only considered valid for procedure codes specific to body parts that exist only twice in the body, once on the left and once on the right (paired body parts). For example, eye procedures (e.g. cataract surgery) and knee procedures (e.g. total knee replacement). Modifiers LT and RT should be used when a procedure was performed on only one side of the body, to identify which one of the paired organs was operated upon.	LT and RT are not considered valid for toe procedures, excision of lesions, tendon/ligament injections (20550), or needle placements, etc. (Use finger and toe modifiers for finger and toe procedure codes; use eyelid modifiers for eyelid procedures.) If the code description is for a structure that occurs multiple times on one side of the body (e.g. fingers, tendons, nerves, etc.) and is not specific enough for you to be able to mark on a body diagram where the left or right procedure is performed without looking at the medical record (e.g. place an "x" on the left shoulder for 73030-LT), then LT and RT are not valid modifiers. (Modifier -59 may be needed to indicate a separate lesion, separate nerve, separate tendon, etc. for non-paired procedure codes.)
NU, RR	Modifiers NU and RR are only considered valid modifiers for procedure codes (items) that can be either rented or purchased. Modifiers NU and RR are used to clarify which method of use is being billed on a claim when the item is eligible for both rental and/or purchase (e.g. walker, crutches, standard wheelchairs, hospital bed). These are the only codes that will be allowed in combination with either NU or RR.	Do not use modifier NU for an item that cannot be rented. If the item is always purchased, clarification with modifier NU is not needed. It is unnecessary and redundant to use modifier NU for items that are always purchased. The code should be reported without the unnecessary modifier. Examples of items that are always purchased are: anything custom- molded, any supplies, any one-patient- only items such as wrist/leg braces, etc. Procedure codes for these items should be reported without modifier NU.

SG	Modifier SG = ASC facility service Modifier SG is only valid for surgical codes	Do not use modifier SG with related HCPCS codes for DME, surgical implants, equipment used during the surgery, supplies etc.These items are related to the surgery, and in some cases are eligible for separate reimbursement, but they are not facility fees.

Molina values and appreciates the services you provide to our Members. Thank you for working together with us and for your continued support.

Please contact your Provider Service Representative if you have any questions or you may contact the Provider Services Department at (630) 203-3965 or via email at IllinoisProviders@MolinaHealthcare.com.

Modifier definitions

Modifier 24 - Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period.

Modifier 25 - Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service

Modifier 26 - Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier 26 to the usual procedure number.

Modifier TC - Technical Component. Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians. However, portable x-ray suppliers only bill for technical component and should utilize modifier TC. The charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.

Modifier LT - Left side (used to identify procedures performed on the left side of the body)

Modifier RT - Right side (used to identify procedures performed on the right side of the body)

Modifier NU - New equipment

Modifier RR - Rental (use the RR modifier when DME is to be rented)