PREFERRED HEALTH SYSTEMS
A Coventry Health Care Plan

Modifiers Affecting Payment

Modifier	Rules	Reimbursement
22- UNUSUAL PROCEDURAL SERVICES	Provider must provide documentation that supports the need for the use of the modifier on the claim. 22 modifiers should not be submitted on unlisted codes	125% of the applicable fee schedule amount
25- EVALUATION MANAGEMENT SERVICES BY SAME PHYSICIAN	The applicable E&M code should be submitted with the 25 modifier when done in conjunction with a surgical procedure	Will reimburse the applicable evaluation and management code in addition to the procedure listed on the claim with the use of the 25 modifier.
50- BILATERAL PROCEDURE	Bilateral procedures should be billed on one line of the claim form with one unit. Radiology procedures performed bilaterally should be submitted with the RT and LT modifiers, not 50.	150% of the applicable fee schedule amount on eligible surgical procedures.
51- MULTIPLE PROCEDURES	Multiple procedures should be billed with the 51 modifier as indicated. The primary procedure will be the procedure with the highest RVU amount. PHS utilizes the listing in CPT for those codes eligible for 51 modifiers.	50% of the applicable fee schedule amount
52- REDUCED SERVICES	Use this modifier to denote services where the basic service is not disturbed but not completely performed	50% of the applicable fee schedule amount
53- DISCONTINUED PROCEDURE	Use this modifier to denote services where the procedure is started but the physician elects to terminate the procedure for the well being of the patient.	50% of the applicable fee schedule amount
54- SURGICAL CARE ONLY		80% of the applicable fee schedule amount
55- POSTOPERATIVE MANAGEMENT ONLY	Postoperative care should be billed with the date of service of the surgical procedure. When only a portion of the post op care is being billed for list out the number of days of care that were billed	20% of the applicable fee schedule amount
59- DISTINCT PROCEDURAL SERVICE	Excessive use of this modifier can cause a provider to qualify for SIU audit.	100% of the applicable fee schedule amount
62- CO-SURGEONS	When co-surgeons are indicated, PHS will be reviewing all claims associated with the care to be sure that we are not reimbursing globally in addition to co-surgeons	62.5% of the applicable fee schedule amount
73- DISCONTINUED OPERATIVE PROCEDURE PRIOR TO ANESTHESIA	Should be used only by ASC facilities	50% of the applicable fee schedule amount
74- DISCONTINUED OPERATIVE PROCEDURE AFTER ANESTHESIA	Should be used only by ASC facilities	100% of the applicable fee schedule amount

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80-82- ASSISTANT SURGEON	PHS utilizes the CMS listing of procedures that allow for an assist at surgery. For those procedures that CMS indicates are allowed with documentation, the provider should submit supporting documentation in order to prove medical necessity.	25% of the applicable fee schedule amount
AS- PA/ARNP ASSISTANT DURING SURGERY	PA/ARNP providers billing for assistant surgery services should bill with the AS modifier.	25% of the applicable fee schedule amount
SG- AMBULATORY SURGICAL CENTER	Free Standing ASC facilities should bill procedures with the SG modifier	100% of the applicable ASC fee schedule amount
26- PROFESSIONAL COMPONENT		100% of the applicable fee schedule amount indicated for the professional portion of the procedure
TC- TECHNICAL COMPONENT		100% of the applicable fee schedule amount indicated for the technical portion of the procedure