<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Services and Modifiers Not Reimbursable to Health Care Professionals</th>
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<tbody>
<tr>
<td>Summary</td>
<td>This policy addresses codes and modifiers not intended for reimbursement to health care professionals when reported on a CMS-1500 form or its electronic equivalent.</td>
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<td>Policy Statement</td>
<td>Codes</td>
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<td>All codes are published in the National Physician Fee Schedule (NPFS) by the Centers for Medicare and Medicaid (CMS) with an assigned status code. The status code indicates whether the code is separately payable if the service is covered.</td>
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<td>Consistent with CMS, Medica will deny certain codes with an NPFS status indicator of E and X, along with all status Q and M codes.</td>
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<td>Modifiers</td>
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<td>In accordance with correct coding guidelines, Medica will not reimburse modifiers 27, 73, 74 and CP when reported by physicians or other health care professionals on a CMS-1500 form or its electronic equivalent. These modifiers are intended to be used for services billed by ambulatory surgery centers (ASCs) and hospitals for outpatient services only, when billed on the UB04 form.</td>
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<td>Modifiers SE and SL reported by physicians or other health care professionals indicates a service has been funded or a vaccine was provided free of charge by the state or federal government; therefore, no cost has been incurred requiring reimbursement. Because modifier SE has two descriptions, ambulance transport codes reported with modifier SE will only be considered eligible for reimbursement when reported by ambulance providers.</td>
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<td>Modifiers reported by physicians or other health care professionals representing services that are court ordered or are funded by a government agency are not eligible for reimbursement. These modifiers include: H9, HU, HV, HW, HX, HY, HZ, QJ and TR.</td>
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<tr>
<td>Definitions</td>
<td>Modifiers:</td>
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<td>• <strong>27</strong> – Multiple Outpatient Hospital E/M Encounters on the Same Date.</td>
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<td>• <strong>73</strong> – Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia.</td>
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<td></td>
<td>• <strong>74</strong> – Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia.</td>
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• **CP** – Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification (c-APC) procedure, but reported on a different claim

• **H9** – Court ordered

• **HU** – Funded by child welfare agency

• **HV** – Funded state addictions agency

• **HW** – Funded by state mental health agency

• **HX** – Funded by county/local agency

• **HY** – Funded by juvenile justice agency

• **HZ** – Funded by criminal justice agency

• **PO** – Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments

• **QJ** – Services/items provided to a prisoner or patient in state or local custody, however the estate or local government, as applicable, meets the requirements in 42 CFR 411.4(B)

• **SE** – Two definitions:
  o State and/or federally-funded programs/services
  o Ambulance transportation from scene of accident or acute event to residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)

• **SL** – State supplied vaccine

• **TR** – School-based individualized education program (IEP) services provided outside the public school district responsible for the student.

**Status E** – Excluded from Physician Fee Schedule by regulation. These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the fee schedule for these codes. Payment for them, when covered, generally continues under reasonable charge procedures.

**Status M** – Measurement codes. Used for reporting purposes only.

**Status Q** – Therapy functional information code. (Used for required reporting purposes only.)
**Stat**

Status X – Statutory Exclusion. These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule.

**Code Lists**

Services Not Reimbursable to Health Care Professionals Code List  
Modifiers Not Reimbursable to Health Care Professionals

**Resources**

- Centers for Medicare and Medicaid Services (CMS)  
- Healthcare Common Procedure Coding System (HCPCS)  
- National Physician Fee Schedule (NPFS)

**Effective Date**  
11/15/2014

**Revision Updates**

- 01/01/2017 Annual code update  
- 09/22/2016 Annual policy review  
- 07/01/2016 Code list update  
- 04/01/2016 Code list update  
- 02/14/2016 Modifier added  
- 01/01/2016 Annual code update  
- 01/01/2015 Annual code update  
- 10/15/2015 Annual policy review  
- 05/24/2015 Modifiers added  
- 02/14/2015 Modifiers added; policy name change  
- 01/01/2015 Annual code update