Payment Policy: Modifier Reimbursement

Reference Number: NH.PP.136
Product Types: NH Medicaid
Effective Date: 04/01/2026
Last Review Date: 01/29/2026

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Medical Coding Modifiers are two characters appended to procedure codes to provide additional details about the medical procedure, service(s) or supply that was performed without changing or altering the American Medical Association (AMA) Current Procedural Terminology (CPT) definition of the procedure or the procedure code. The AMA publishes the list of HCPCS Level I (CPT) Modifiers, while CMS publishes the list of HCPCS Level II Modifiers.

In addition to maintaining accurate claim payment and reimbursement, using the appropriate modifiers is crucial for accurate coding and billing. The AMA, public-domain specialty societies, and the Centers for Medicare and Medicaid Services (CMS) decide whether payment modifiers are permissible for billing with specific procedure codes

This policy has been established to define NH Healthy Families' payment structure for specific modifier reimbursement.

Application
This policy applies to Professional and Outpatient institutional claims.

Reimbursement
Same Day - Separate & Distinct Procedural Service Modifiers
Modifiers to report same day, separate and distinct procedural services must be reported to identify procedures and/or services that are distinct and unrelated. Medical record documentation must clearly support the different session and/or procedure, not normally performed on the same day by the same physician and/or group. See specific payment policies for more information.

State Supplied Vaccines
Vaccines supplied by the state of New Hampshire, at no charge to providers, must be reported with modifier SL on the vaccination code only. The Health Plan does not reimburse providers for state supplied vaccines.

Canceled Procedures
The Health Plan will not reimburse a provider for any surgical procedures that are canceled or postponed, for any reason, before the procedure is initiated.

Other Modifier Related Policies
There may be instances where services require the Health Plan to make exceptions by utilizing modifiers. In these instances, the Health Plan will give specific instructions on how to bill the

applicable services. Modifier billing instructions on other Health Plan policies or notifications will supersede the table below.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current 2024 manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Modifier	Description	% of Allowable
Professional/Technical Components		
TC	Technical Component	Fee Schedule
26	Professional Component	Fee Schedule
DME Rental		
RR	Rental (use for all DME rental)	See DME Manual Pricing Payment Policy
Global Surgery		
54	Surgical Care Intraoperative Only	80%
55	Postoperative Management Only	20%
78	Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period	70%
Assist/Co/Team Surgeons		
62	Two Surgeons	62.5%
66	Surgical Team	62.5%
80	Assistant Surgeon	16%
81	Minimum Assistant Surgeon	16%
82	Assistant Surgeon (when qualified resident surgeon not available)	16%
AS	Nurse practitioner, Physician assistant, or clinical nurse specialist services for assistant at surgery * The use of modifier "AS" to indicate assistant at surgery services should only be reported by non-physician practitioners billing under their own provider number.	16%
Discontinued/ Reduced Services		
53	Discontinued Procedure	25%
52	Reduced Services	50%
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia	50%

74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia	80%
Anesthesia		
AA	Anesthesia services performed personally by anesthesiologist	100%
AD	Medical supervision for more than four concurrent anesthesia procedures is provided	100%
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals	50%
QX	CRNA service: with medical direction by a physician	50%
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist	50%
QZ	CRNA performed services without medical direction	100%
Infusion		
SH	Second, concurrently administered infusion therapy	50%
SJ	Third or more concurrently administered infusion therapy	25%
Non-Physician Practitioners		
SA	Nurse practitioner rendering service in collaboration with a physician	100%
SB	Certified Nurse Midwife (CNM)	100%
Other		
22	Reviewed by Medical Director for additional compensation	120%
50	Bilateral Procedure (Professional Services)	150%
SL	State-supplied vaccine	Priced at $0 for vaccine only

Documentation Requirements
Not Applicable

Additional Information
Not Applicable

Related Documents or Resources
Not Applicable

References
1. *Current Procedural Terminology* (CPT®), 2025

2. *Centers for Medicare and Medicaid Services*, CMS Manual System and other CMS publications and services.

Revision History	
12/10/2025	Policy Creation

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.