NAME
ADDRESS1
ADDRESS2
CITY, STATE ZIP

Re: Commercial Plan Payment Policy Changes

Dear Provider:

At Health New England (HNE), we are committed to working with our provider network to make sure that you have the tools and information you need to provide the best care and service to our members. One of the ways we do this is by periodically notifying you of changes to our administrative processes.

We have attached a grid explaining upcoming changes to some HNE payment policies that will go into effect **October 1, 2012**.

If you have any questions, please contact Provider Relations at 413.233.3313 or toll-free at 800.842.4464, extension 5000. A representative is available to assist you between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday.

Sincerely,

Erik B. Johnson
Provider Relations Manager

Policy	Commercial Plan Payment Policy Change Effective 10/1/12
Modifier 52	The purpose of this modifier is to report when a procedure is partially reduced or eliminated at the physician's discretion. Modifier 52 is used to report procedures that are discontinued by the physician due to unforeseen circumstances and is used to indicate partial reduction or discontinuation of procedures. • This modifier is used to report a service or procedure that is partially reduced or eliminated at the physician's election. • Modifier 52 is appended to the code for reduced procedure. • Modifier 52 is not used to report an elective cancellation of a procedure before anesthesia induction and/or surgical preparation in the operating suite. • Modifier 52 cannot be used if the procedure is discontinued after administration of anesthesia. • Modifier 52 will price the procedure at 50% of the allowable charge, if a pre-set reduction reimbursement agreement has not been made by the provider(s) and HNE. If a pre-set reduction reimbursement agreement has been made, modifier 52 will be priced according to the terms outlined in the contract. Clinical Information Requirements: • Medical records are not required with the claim, but must be available upon request. • Clinical information documented in the patient's record must support the use of this modifier. • Documentation should include a statement indicating in what way the procedure or service was reduced.
Modifier 53	The purpose of this modifier is to report when a procedure is discontinued. Modifier 53 is used to report procedures that are discontinued by the physician due to extenuating circumstances or those that threaten the well being of the patient. • Modifier 53 must be appended to a surgical code or medical diagnostic code when the procedure is discontinued because of extenuating circumstances • This modifier is used to report a service or procedure when the service or procedure is discontinued after anesthesia is administered to the patient. • This modifier is not used to report an elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. • Modifier 53 cannot be used when a laparoscopic or endoscopic procedure is converted to an open

	procedure code. • Modifier 53 will price the procedure at 50% of the allowable charge, if a pre-set reduction reimbursement agreement has not been made by the provider(s) and HNE. If a pre-set reduction reimbursement agreement has been made, modifier 53 will be priced according to the terms outlined in the contract. Clinical Information Requirements: • Medical records are not required with the claim, but must be available upon request. • Clinical information documented in the patient's record must support the use of this modifier. • Documentation must include a statement indicating at what point the procedure was discontinued. The extenuating circumstances preventing the completion of the procedure must also be documented.
Modifier 62	The purpose of this modifier is to report when two surgeons work together as primary surgeons performing distinct parts of a procedure. Some surgical procedures may require the skill of two surgeons. The condition of the patient or the complexity of the surgery may warrant these services. In these cases, the additional surgeon is not acting as 'assistant at surgery' but as an equal "co-surgeon". Modifier 62 is used to show that two surgeons are required. • Each surgeon must report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. • Each surgeon must also report the same procedure code. • If additional procedure(s), including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added, if appropriate and covered under the provider contract. • If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with the modifier 80 or 82 added, as appropriate. • Multiple surgery reduction applies if more than one procedure is performed during the same operative session. • Modifier 62 will price the procedure at 62.5% of the allowable charge, if a pre-set co-surgeon reimbursement agreement has not been made by the provider(s) and HNE. If a pre-set co-surgeon reimbursement agreement has been made, modifier 62 will be priced according to the terms outlined in the contract. • HNE will follow CPT guidelines relating to use of modifier 62.