Anthem Blue Cross and Blue Shield Healthcare Solutions | Medicaid Managed Care

Reimbursement Policy	
Subject: **Modifier Usage**	
Policy Number: **G-06006**	Policy Section: **Coding**
Last Approval Date: **01/16/2024**	Effective Date: **01/16/2024**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **providers.anthem.com/nv**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Anthem covered the service for the member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Anthem strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

NVBCBS-CD-RP-066401-24-CPN65974 August 2024

Policy

Anthem allows reimbursement for covered services provided to eligible members when billed with appropriate procedure codes and appropriate modifiers when applicable, unless provider, state, federal, or CMS contracts or requirements indicate otherwise.

Reimbursement is based on code set combinations submitted with correct modifiers. Certain modifiers require supporting documentation to be submitted with the claim. Refer to the Specific Modifier policies for guidance on documentation submission. Anthem reserves the right to review adherence to correct coding for high-volume modifiers.

Applicable electronic or paper claims billed without the correct modifier in the correct format may be rejected or denied. The modifier must be in capital letters if alpha or alphanumeric. Rejected or denied claims must be resubmitted with the correct modifier in conjunction with the code set to be considered for reimbursement. Corrected and resubmitted claims are subject to timely filing guidelines. The use of correct modifiers does not guarantee reimbursement.

Reimbursement Modifiers
Reimbursement modifiers affect payment and denote circumstances when an increase or reduction is appropriate for the service provided. The modifiers must be billed in the primary or first modifier field locator.

Informational Modifiers Impacting Reimbursement
Informational modifiers determine if the service provided will be reimbursed or denied. Modifiers that impact reimbursement should be billed in modifier locator fields after reimbursement modifiers, if any.

Informational Modifiers Not Impacting Reimbursement
Informational modifiers are used for documentation purposes. Modifiers that do not impact reimbursement should be billed in the subsequent modifier field locators. Anthem reserves the right to reorder modifiers to reimburse correctly for services provided.

In the absence of state-specific modifier guidance, Anthem will default to CMS guidelines.

Related Coding	
Description	**Comments**
Reimbursement Modifiers	**Reimbursement Modifiers**
In the absence of a modifier specific reimbursement policy, providers should refer to their provider manual and state and federal guidelines for guidance on modifiers affecting reimbursement or modifiers reimbursed specific to state and federal payment methodologies.	

Policy History	
01/16/2024	Review approved and effective: updated Reimbursement Modifiers code list to include related reimbursement policies

02/09/2022	Review approved and effective: updated policy template; added Reimbursement Modifiers Listing — Code List as separate document; updated Related Coding section with a note: In the absence of a modifier specific reimbursement policy, providers should refer to their provider manual, and state and federal guidelines for guidance on modifiers affecting reimbursement or modifiers reimbursed specific to state and federal payment methodology; expanded Modifier FB to Facility providers
10/08/2020	Review approved and effective: updated References and Research Materials, Related Policies, Exhibit A Modifiers 58, 90, CO, CQ, FB, GN, GO, and GP
10/03/2018	Review approved and effective: review adherence to correct coding policy language added; Exhibit A Modifier FX updated
08/31/2017	Review approved and effective: Exhibit A updated — Modifier QF added
04/03/2017	Review approved: policy template updated
08/01/2016	Review approved and effective: Exhibit A updated — Modifier CT added
09/22/2014	Review approved: Exhibit A updated — Modifier 99 and AG added; Background section/policy template updated
06/17/2013	Review approved**:** disclaimer updated
07/30/2012	Review approved and effective 03/14/2013: added CMS default language; Exhibit A updated — Modifier AQ updated, PA-PD modifiers removed, and Modifier SA added; policy template and background section updated
02/14/2011	Review approved: claims rejection/denial and resubmission requirements clarified; modifier requirements clarified; Reimbursement Modifiers Listing (Exhibit A) added; Background and Related Policies sections updated; policy template updated
04/24/2007	Review approved: reimbursement and informational modifiers clarified; acceptable modifier format clarified; reordering modifiers for correct reimbursement clarified; policy template updated
03/30/2006	Initial approval and effective

References and Research Materials
This policy has been developed through consideration of the following: • CMS • Optum EncoderPro 2023 • State contract • State Medicaid

Definitions
General Reimbursement Policy Definitions

Related Policies and Materials
Claims Timely Filing
Consultations
Distinct Procedural Services (Modifiers 59, XE, XP, XS, XU)

Documentation Standards for Episodes of Care
Duplicate or Subsequent Services on the Same Date of Service
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
Modifier 22
Modifier 24
Modifiers 25 and 57
Modifiers 26 and TC
Modifiers 50 and 51: Multiple and Bilateral Surgery
Modifiers 52, 53, 73, and 74: Reduced or Discontinued Services
Modifier 62
Modifier 63
Modifier 66
Modifier 76
Modifier 77
Modifier 78
Modifiers 80, 81, 82, and AS: Assistant at Surgery
Modifier 90
Modifier 91
Modifiers LT and RT
Multiple Delivery Services
Nurse Practitioner and Physician Assistant Services
Physician Standby Services
Portable/Mobile/Handheld Radiology Services
Preadmission Services for Inpatient Stays
Preventive Medicine and Sick Visits on the Same Day
Professional Anesthesia Services
Provider Preventable Conditions
Split-Care Surgical Modifiers
Technology Assisted Surgical Procedures
Transportation Services
Vaccines for Children