| Reimbursement Policy | |
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| Subject: **Modifier Usage** | |
| Policy Number: **G-06006** | Policy Section: **Coding** |
| Last Approval Date: **02/09/2022** | Effective Date: **02/09/2022** |

**** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.anthem.com/ca.** ****

## Disclaimer

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Anthem Blue Cross (Anthem) if the service is covered by Medi-Cal Managed Care. 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 CPT® codes, HCPCS codes, and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating 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.

Anthem reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations.

Anthem reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to our provider site.

## 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 and/or requirements indicate otherwise.



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Reimbursement is based on the code-set combinations submitted with the correct modifiers. The use of certain modifiers requires the provider to submit supporting documentation along with the claim. Refer to the specific modifier policies for guidance on documentation submission. We reserve 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. We reserve the right to reorder modifiers to reimburse correctly for services provided.
In the absence of state-specific modifier guidance, we will default to CMS guidelines.

**Related Coding**

| Description | Comment |
|---|---|
| Reimbursement Modifiers | **Reimbursement Modifiers**<br>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**

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| 02/09/2022 | Policy review 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; added Modifier CO & CQ for Medicare Advantage/MMP only |

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| 10/08/2020 | Review approval and effective 10/08/2020: Updated References and Research Materials, Related Policies, Exhibit A Modifiers 58, 90, FB, GN, GO, GP |
| 10/03/2018 | Review approved and effective 10/03/2018: Review adherence to correct coding policy language added; Exhibit A Modifier FX updated |
| 08/31/2017 | Review approved and effective 08/31/2017: Exhibit A updated — Modifier QF added |
| 07/19/2017 | Initial approval 07/19/2017 and effective 10/05/2017 |

## References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- California Department of Health Care Services Policies
- Anthem contract with the California Department of Health Care Services
- Optum Encoder Pro for Payers Professional

## Definitions

General Reimbursement Policy Definitions

## Related Policies and Materials

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| Assistant at Surgery (80/81/82/AS) |
| 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: Increased Procedural Service |
| Modifier 24: Unrelated Evaluation and Management Service by Same Physician during Postoperative Period |
| Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by Same Physician on Same Day of Procedure or Other Service |
| Modifier 26 and TC: Professional and Technical Component |
| Modifier 57: Decision for Surgery |
| Modifier 62: Co-Surgeons |
| Modifier 63: Procedure on Infants Less Than 4kg |
| Modifier 66: Surgical Teams |
| Modifier 76: Repeat Procedure by Same Physician |
| Modifier 77: Repeat Procedure by Another Physician |
| Modifier 78: Unplanned Return to Operating/ Procedure Room by Same Physician Following Initial Procedure for a Related Procedure during Postoperative Period |
| Modifier 90: Reference (Outside) Laboratory and Pass-Through Billing |
| Modifier 91: Repeat Laboratory Test |
| Modifier LT and RT: Left Side-Right Side Procedures |
| Multiple and Bilateral Surgery: Professional and Facility Reimbursement |
| Multiple Delivery Services |
| Physician Standby Services |

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| Portable-Mobile-Handheld Radiology Services |
| Preadmission Services for Inpatient Stays |
| Preventive Medicine and Sick Visits on the Same Day |
| Professional Anesthesia Services |
| Reimbursement for Reduced or Discontinued Services |
| Robotic Assisted Surgery |
| Split Care Surgical Modifiers |
| Transportation Services |
| Vaccines for Children |