

Commercial Reimbursement Policy

Subject: **Modifier Usage - Facility**

Policy Number: **C-23005**

Policy Section: **Facilities**

Last Approval Date: **11/08/2023**

Effective Date: **05/01/2024**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem Blue Cross and Blue Shield (Anthem) 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive 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.

Policy

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

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.

Note: This is not an all-inclusive list of accepted facility CPT and HCPCS Modifiers

Related Coding

| Description | Comments |
|--------------------|------------------------------------|
| Facility Modifiers | Facility Modifiers |

Policy History

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| 11/08/2023 | Initial approval 11/08/2023 and effective 05/01/2024 |
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References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2023

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

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| Laboratory and Venipuncture Services - Professional and Facility |
| Modifier FB - Professional and Facility |
| Modifier Rules - Professional |
| Multiple Diagnostic Imaging - Facility |
| Multiple Surgery - Facility |
| Pharmaceutical Waste - Professional and Facility |
| Provider Preventable Conditions - Professional and Facility |
| Virtual Visits - Professional and Facility |

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.

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