Anthem Blue Cross and Blue Shield

Include Modifiers to Help Ensure Accurate Payment

Codes not recognized by Original Medicare are considered by Anthem Blue Cross and Blue Shield Medicare Advantage as not reimbursable unless otherwise noted for both individual and group-sponsored claims.

During the past year, some providers have found that certain individual and group-sponsored claims are denied for missing or inconsistent modifiers as the claims are not consistent with CMS payment guidelines. Please ensure you use the most current and appropriate CMS codes and modifiers when submitting your claims. For example:

DME rental claims should include the following modifiers:

- **KH** – first rental month
- **KI** – second and third rental month
- **KJ** – fourth through fifteenth month

Therapy claims should include the following modifiers:

- **GP** – Physical Therapy
- **GO** – Occupational Therapy
- **GN** – Speech Language Pathology

In addition to anesthesia pricing modifiers **AD, QK, QY, QX**, anesthesia claims should include the following informational modifiers when appropriate:

- **AA**: Anesthesia Services Performed Personally by Anesthesiologist
- **QZ**: CRNA Service without medical direction by a Physician

DME providers should use the most current, accurate codes for insulin pump supplies. For example, use code K0552 for the sterile syringe cartridges for external drug infusion supplies and not A4232, which is not covered by Medicare.

Providers should use Modifier -50 to report bilateral procedures that are performed at the same operative session as a single line item. Do not use modifiers RT and LT when modifier -50 applies. Do not submit two line items to report a bilateral procedure using modifier-50. Please refer to the Medicare Claims Processing Manual, Chapter 4, Section 20.6.2 for additional guidance.

Providers are reminded to first refer to their provider contracts for reimbursement guidelines. Reimbursement policies provide general reimbursement criteria which may differ for individual providers based on their contract information. It is important to note that these policies may be superseded by mandates in provider contracts, federal or CMS contracts and/or requirements.
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