COMMON GROUND
HEALTHCARE COOPERATIVE

REIMBURSEMENT POLICY STATEMENT
Wisconsin Marketplace

Policy Name & Number	Date Effective
Modifiers-WI MP-PY-1554	01/01/2025
Policy Type	
REIMBURSEMENT	

Reimbursement Policies are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design, and other factors are considered in developing Reimbursement Policies.

In addition to this policy, reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

This policy does not ensure an authorization or reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination. We may use reasonable discretion in interpreting and applying this policy to services provided in a particular case and we may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

A. Subject
Modifiers

B. Background
Reimbursement policies are designed to assist providers when submitting claims to Common Ground Healthcare Cooperative ("CGHC") and are routinely updated to promote accurate coding and provide policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify a member's eligibility.

Reimbursement modifiers are two-digit codes that provide a way for physicians and other qualified health care professionals to indicate that a service or procedure has been altered by some specific circumstance. Modifiers can be found in the appendices of both CPT and HCPCS manuals. Use of a modifier does not change the code or the code's definition. Examples of modifiers use include:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same procedure.
- To indicate that a procedure was performed on the left side, right side, or bilaterally.
- To report multiple procedures performed during the same session by the same health care provider.
- To indicate multiple health care professionals participated in the procedure.
- To indicate a subsequent procedure is due to a complication of the initial procedure.

Although CGHC accepts the use of modifiers, use does not guarantee reimbursement. Some modifiers increase or decrease the reimbursement rate, while others do not affect the reimbursement rate. CGHC may verify the use of any modifier through post-payment audit. Using a modifier inappropriately can result in the denial of a claim or an incorrect reimbursement for a product or service. All information regarding the use of these modifiers must be made available upon CGHC's request.

C. Definitions

- **Current Procedural Terminology (CPT)** – Codes that are issued, updated, and maintained by the American Medical Association (AMA) that provide a standard language for coding and billing medical services and procedures.
- **Healthcare Common Procedure Coding System (HCPCS)** – Codes that are issued, updated, and maintained by the American Medical Association (AMA) that provides a standard language for coding and billing of products, supplies, and services not included in the CPT codes.
- **Modifier** – Two-character codes used along with a CPT or HCPCS code to provide additional information about the service or procedure rendered.

D. Policy

It is the responsibility of the submitting provider to submit accurate documentation of services performed. Providers are expected to use the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided according to the following industry standard guidelines (may not be all-inclusive):

- Centers for Medicare and Medicaid Services (CMS) regulations
- Medicare National Correct Coding Initiative (NCCI) editing regulations
- American Hospital Association (AHA) billing rules
- Current Procedural Terminology (CPT)
- Healthcare Common Procedure Coding System (HCPCS)
- International Classification of Diseases, Tenth Edition Clinical Modification (ICD-10 CM) and Procedure Coding System (PCS)
- National Drug Codes (NDC)
- Diagnosis Related Group (DRG) regulations

The inclusion of a code in a policy does not imply any right to reimbursement or guarantee claims payment.

E. Conditions of coverage

Reimbursement is dependent upon, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. In the absence of State specific instructions, the CMS guidelines will apply. Please refer to the individual fee schedule for appropriate codes.

Providers must follow proper billing, industry standards, and state compliant codes on all claim submissions. The use of modifiers must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, CGHC policies apply to both participating and nonparticipating providers and facilities.

In the event of any conflict between this policy and a provider's contract with CGHC, the provider's contract will be the governing document.

F. Related policies/rules

NA

G. Review/revision history

	DATE	ACTION
Date Issued	09/11/2025	New policy
Date Revised		
Date Effective	01/01/2025	
Date Archived		

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.

H. References

1. *Billing 340B Modifiers Under the Hospital Outpatient Prospective Payment System (OPPS).* US Centers for Medicare and Medicaid Services. March 3, 2023. Accessed June 3, 2024. www.cms.gov
2. CPT® overview and code approval. American Medical Association. Accessed June 3, 2024. www.ama-assn.org
3. *Medicare Claims Processing Manual, XII: Physicians/Nonphysician Practitioners*. US Centers for Medicare and Medicaid Services. March 7, 2024. Accessed June 3, 2024. www.cms.gov
4. *Medicare Claims Processing Manual, XIV: Ambulatory Surgical Centers*. US Centers for Medicare and Medicaid Services. March 24, 2023. Accessed June 3, 2024. www.cms.gov
5. Optum Encoder Pro. 2024. Accessed June 3, 2024. www.encoderprofp.com