PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Payment Policy

cmi_145898

Title	**Modifier KX - Requirements specified in the medical policy have been met**		
Number	**CP.PP.378.v1.5**		
Last Approval Date	07/08/24	**Original Effective Date**	02/11/13
Replaces	N/A		
Cross Reference			

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define when the Plan recognizes services submitted with Modifier KX that are submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company, and Premera Blue Cross HMO lines of business and products.
Policy	The Plan recognizes modifier KX when appended to a service to indicate that the compliance parameters of a Plan medical policy have been met. The patient's medical records must document the compliance and must be available for viewing upon request. Codes submitted without modifier KX may be denied reimbursement per applicable medical policy parameters.
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined at Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	None
Laws, Regulations & Standards	None
References	• Centers for Medicare and Medicaid Services (CMS) • CMS Healthcare Common Procedure Coding System (HCPCS) code set

Policy Owner Review	Payment Integrity Oversight Committee
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.
Annual Review Dates	07/08/24; 10/12/23; 11/07/22; 12/02/21; 12/30/20; 01/10/20; 01/10/19; 01/15/18; 01/24/17; 01/28/16; 02/06/15; 02/08/14; 02/11/13

Version History	01/15/18	Deleted Medical Policy 1.01.524 reference in the “Cross Reference” section
	01/10/18	Annual Review; no changes made
	01/10/20	Annual review; no changes made
	12/30/20	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P claim forms
	12/02/21	Annual review; no changes
	11/07/22	Annual review; no changes
	10/12/23	Annual review; no changes
	07/08/24	Annual review; no changes