KX Modifier Policy (Medicare)

**Policy Number**: 2017R7115A  
**Annual Approval Date**: 3/8/2017  
**Approved By**: Reimbursement Policy Oversight Committee

**IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY**

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

**Other factors affecting reimbursement supplement, modify or, in some cases, supersed this policy.** These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee’s benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

UnitedHealthcare Community Plan uses a customized version of the Optum Claims Editing System known as iCES Clearinghouse to process claims in accordance with UnitedHealthcare Community Plan reimbursement policies.

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**Application**

This reimbursement policy applies to UnitedHealthcare Community Plan Medicare products.

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Payment Policies for Medicare & Retirement and Employer & Individual please use [this link](#). Medicare & Retirement Policies are listed under Medicare Advantage Reimbursement Policies. Employer & Individual are listed under Reimbursement Policies-Commercial.
Supplier usage of the KX modifier identifies that the requirements identified in the medical policy have been met. Documentation is essential to support that the item is reasonable and necessary and that the specific coverage criteria specified in each policy have been met.

The KX modifier has differing requirements for usage depending on the specific Local Coverage Determination (LCD); suppliers should review the LCDs carefully to understand the documentation requirements and the proper use of the KX modifier for each policy. Below is a list of LCDs which include a KX modifier requirement for some or all items within that specific LCD. Use of the KX modifier with any other DMEPOS is inappropriate usage.

- Ankle-Foot/Knee-Ankle-Foot Orthosis
- Automatic External Defibrillators
- Cervical Traction Devices
- Commodes
- External Infusion Pumps
- Glucose Monitors
- High Frequency Chest Wall Oscillation Devices
- Hospital Beds
- Immunosuppressive Drugs
- Knee Orthoses
- Manual Wheelchair Bases
- Nebulizers
- Negative Pressure Wound Therapy Devices
- Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)
- Oral Appliances for Obstructive Sleep Apnea
- Orthopedic Footwear
- Patient Lifts
- Positive Airway Pressure Devices
- Power Mobility Devices
- Pressure Reducing Support Surfaces
- Refractive Lenses
- Respiratory Assist Devices
- Speech Generating Devices
- Therapeutic Shoes for Persons with Diabetes
- Transcutaneous Electrical Nerve Stimulators (TENS)
- Urological Supplies
- Walkers
- Wheelchair Options and Accessories
- Wheelchair Seating

It is important to remember, if the requirements specified in the LCD are not met the KX modifier must not be used. Most LCDs include a modifier which indicates the documentation requirements are not met by appending either a GA, GY, or GZ modifier if a claim is denied for missing one of these modifiers it must be resubmitted.
<table>
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<th>Reimbursement Guidelines</th>
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<tr>
<td><strong>Ankle-Foot/Knee-Ankle-Foot Orthosis</strong></td>
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| Suppliers must add a KX modifier to the AFO/KAFO base and addition codes only if all of the coverage criteria in the “Indications and Limitations of Coverage and or Medical Necessity” section of the LCDs have been met and evidence of such is retained in the supplier’s files and available to the DME MAC upon request.  
If all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Non-coverage (ANN) or the GZ modifier if they have not obtained a valid ANN. 
Claims lines billed with codes without a KX, GA or GZ modifier will be rejected as missing information. |
| **Automatic External Defibrillators** |
| Suppliers must add a KX modifier to a code only if all of the criteria in the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCDs have been met.  
If all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Non-coverage (ANN) or the GZ modifier if they have not obtained a valid ANN. 
Claim lines billed without a GA, GZ, or KX modifier will be rejected as missing information. |
| **Cervical Traction Devices** |
| Suppliers must add a KX modifier to code E0849 or E0855 only if all of the criteria in the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCDs have been met and evidence of such is maintained in the supplier's files. This information must be available upon request.  
If all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Non-coverage (ANN) or the GZ modifier if they have not obtained a valid ANN. 
Claims lines billed without a KX, GA, or GZ modifier will be rejected as missing information. |
| **Commodes** |
| For all commodes (E0163-E0171), if it is used as a raised toilet seat by positioning it over the toilet, the GY modifier must be added to the code and the KX, GA, or GZ modifier must not be used.  
For all commodes (E0163-E0171), if it is not used as a raised toilet seat, the modifier KX modifier must be added to the code only if all of the coverage criteria as described in the Indication and Limitations of Coverage and/or Medical Necessity section of the LCDs have been met.  
In addition, for a commode chair with seat lift mechanism (E0170 and E0171); the KX modifier must only be used if the patient meets all of the criteria for a seat lift mechanism.  
If all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section of the LCD have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter a GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Non-coverage (ANN) or a GZ modifier if they have not obtained a valid ANN. 
Claim lines billed without a GA, GZ or KX modifier will be rejected as missing information. |
External Infusion Pumps

For all claims for external insulin infusion pumps (E0784) and insulin (J1817), if the results of the patient's C-peptide level or beta cell autoantibody test meet the requirements outlined in section IV of the Coverage and Payment Rules, a KX modifier should be added to the HCPCS code.

In the situation above describing use of the KX modifier, if all of the coverage criteria have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Non-coverage (ANN) or the GZ modifier if they have not obtained a valid ANN. Claims lines billed for the above services without a KX, GA, or GZ modifier will be rejected as missing information. An infusion drug not administered using a durable infusion pump must be billed using the appropriate HCPCS code plus the GY modifier.

Glucose Monitors (These codes are being excluded from edit criteria at this time)

If the patient is being treated with insulin injections, the KX modifier must be added to the code for the monitor and each related supply on every claim submitted. The KX modifier must not be used for a patient who is not treated with insulin injections.

If the patient is not being treated with insulin injections, the KS modifier must be added to the code for the monitor and each related supply on every claim submitted.

Additional documentation requirements apply to: 1) a diabetic patient who is not insulin-treated (KS modifier present) and whose prescribed frequency of testing is more often than once per day, or 2) a diabetic patient who is insulin-treated (KX modifier present) and whose prescribed frequency of testing is more often than three times per day. When refills for quantities of supplies that exceed the utilization guidelines are dispensed, the documentation as described in criteria (d)-(f) in the Indications and Limitations of Coverage and/or Medical Necessity section must be available upon request.

High Frequency Chest Wall Oscillation Devices

Suppliers must add a KX modifier to codes for an HFCWO device and accessories only if all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section of the LCDs have been met.

If all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter GA on the claim line if they have obtained a properly executed Advanced Notice of Non-coverage (ANN) or GZ if they have not obtained a valid ANN. Claim lines billed without a KX, GA, or GZ modifier will be rejected as missing information.

Hospital Beds And Accessories

Suppliers must add a KX modifier to a hospital bed code only if all of the criteria in the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCDs have been met.

The KX modifier should also be added for an accessory when the applicable accessory criteria are met. If the requirements for the KX modifier are not met, the KX modifier must not be used.

If all of the coverage criteria have not been met, the GA or GZ modifier must be added to a claim line for a hospital bed and accessories. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Non-coverage (ANN) or the GZ modifier if they have not obtained a valid ANN.

Claim lines billed without a KX, GA or GZ modifier will be rejected as missing information.

Immunosuppressive Drugs (These codes are being excluded from edit criteria at this time)

The KX modifier must be added to the claim line(s) for the immunosuppressive drug(s) only if:

- The supplier obtains from the ordering physician the date of the organ transplant, and
- The beneficiary was enrolled in Medicare Part A, at the time of the organ transplant (whether or not Medicare paid for the transplant), and
- The transplant date precedes the date of service on the claim.

If these three requirements are not met, the KX modifier may not be added to the claim.
**Knee Orthoses**

Suppliers must add a KX modifier to knee orthoses base and addition codes only if all of the coverage criteria in the “Indications and Limitations of Coverage and or Medical Necessity” section of the LCDs have been met and evidence of such is retained in the supplier’s files and available to the DME MAC upon request.

If all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Non-coverage (ANN) or the GZ modifier if they have not obtained a valid ANN.

Claims lines billed with codes without a KX, GA or GZ modifier will be rejected as missing information.

**Manual Wheelchair Bases**

Suppliers must add a KX modifier to the code for the manual wheelchair base only if all of the coverage criteria in the Indications and Limitations of Coverage section of the Mobility Device (Non-Ambulatory) and Accessories reimbursement policy have been met. If the coverage criteria are not met, the KX modifier must not be used.

If all of the coverage criteria have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Non-coverage (ANN) or the GZ modifier if they have not obtained a valid ANN.

If the wheelchair is only to be used for mobility outside the home, the GY modifier must be added to the code.

Claim lines billed without a KX, GA, GY, or GZ modifier will be rejected as missing information.

**Nebulizers**

Suppliers must add a KX modifier to codes for E0574, J7686, K0730 and Q4074 only if all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section of the LCDs have been met.

If all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter GA on the claim line if they have obtained a properly executed Advanced Notice of Non-coverage (ANN) or GZ if they have not obtained a valid ANN.

Claim lines billed without a KX, GA, or GZ modifier will be rejected as missing information.

**Negative Pressure Wound Therapy Pumps**

Suppliers must add a KX modifier to a code only if all of the criteria in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCDs have been met.

The KX modifier must not be used with an NPWT pump and supplies for wounds if:

1. The pump has been used to treat a single wound and the claim is for the fifth or subsequent month's rental, or
2. The pump has been used to treat more than one wound and the claim is for the fifth or subsequent month’s rental after therapy has begun on the most recently treated wound. In this situation, the KX modifier may be billed for more than four total months of rental.

In all of the situations above describing use of the KX modifier, if all of the coverage criteria have not been met, the GA or GZ modifier must be added to a claim line for the NPWT pump and supplies. When there is an expectation of a reasonable and necessary denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Non-coverage (ANN) or the GZ modifier if they have not obtained a valid ANN.

Claim lines billed without a KX, GA or GZ modifier will be rejected as missing information.

**Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)**

If aprepitant (J8501) and dexamethasone (J8540) are used in conjunction with one of the anticancer chemotherapeutic agents listed in the Indications and Limitations of Coverage section of the LCDs have been met, a KX modifier must be added to each code.
If aprepitant and dexamethasone are not used in conjunction with one of the anticancer chemotherapeutic agents listed in the Indications and Limitations of Coverage section of the LCDs, the GA or GZ modifier must be added to a claim line for aprepitant or dexamethasone. When there is an expectation of a denial as not reasonable and necessary, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Noncoverage (ANN) or the GZ modifier if they have not obtained a valid ANN. Claim lines billed without a KX, GA, or GZ modifier will be rejected as missing information.

**Oral Appliances for Obstructive Sleep Apnea**

Suppliers must add a KX modifier to a code only if all of the criteria in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy have been met. If the requirements for the KX modifier are not met, the KX modifier must not be used.

If all of the coverage criteria have not been met, the GA or GZ modifier must be added to a claim line for the oral appliance. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Noncoverage(ANN) or the GZ modifier if they have not obtained a valid ANN. Claim lines billed without a GA, GZ, or KX modifier will be rejected as missing information.

**Orthopedic Footwear**

When billing for a shoe that is an integral part of a leg brace or for related modifications, inserts, heel/sole replacements or shoe transfer, a KX modifier must be added to the code. If the shoe or related item is not an integral part of a leg brace, the KX modifier must not be used.

If the shoe and related modifications, inserts, and heel/sole replacements are not an integral part of a brace, the GY modifier must be added to each code.

If a KX or GY modifier is not included on the claim line, it will be rejected as missing information.

When billing for prosthetic shoes (L3250) and related items, an ICD-10 diagnosis code (specific to the 5th digit), describing the condition which necessitates the prosthetic shoes, must be included on each on each claim for the prosthetic shoes and related items.

When code L3649 with a KX modifier is billed, the claim must include a narrative description of the item provided as well as a brief statement of the medical necessity for the item. This must be entered in the narrative field of an electronic claim.

**Patient Lifts**

Suppliers must add a KX modifier to codes E0636, E1035 and E1036 only if all of the coverage criteria in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy have been met and evidence of such is retained in the supplier’s files and available to the DME MAC upon request.

If all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Noncoverage (ANN) or the GZ modifier if they have not obtained a valid ANN.

Claims lines billed with codes without a KX, GA or GZ modifier will be rejected as missing information.

**Initial Coverage (First Three Months):**

On claims for the first through third months, suppliers must add a KX modifier to codes for PAP equipment (E0470 or E0601) and accessories only if all of the criteria in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy "Initial Coverage" have been met.

**Continued Coverage Beyond The First Three Months Of Therapy:**

On the fourth month’s claim (and any month thereafter), the supplier must add a KX modifier to codes for PAP equipment (E0470 or E0601) and accessories only if both the "Initial Coverage" criteria and the "Continued Coverage" criteria in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy have been met.

If the supplier does not obtain information from the physician that the beneficiary has demonstrated improvement in their OSA symptoms and is adhering to PAP therapy in time for submission of the fourth or succeeding months’ claims, the supplier may still submit the claims, but a KX modifier must not be added. If the supplier chooses to hold claims for the fourth and succeeding months pending receipt of information
from the treating physician that the beneficiary received a clinical re-evaluation between the 31st and 91st day, had documented improvement in OSA symptoms and is adhering to PAP therapy, those claims may then be submitted with the KX modifier.

If the supplier chooses to hold claims for the fourth and succeeding month pending receipt of information from the treating physician but learns that the beneficiary did not receive a clinical re-evaluation between the 31st and 91st day but rather was re-evaluated at a later date and had documented improvement in OSA symptoms and is adhering to PAP therapy, those claims may then be submitted with the KX modifier but only for dates of service following the date of the clinical re-evaluation.

For a PAP device dispensed prior to November 1, 2008, if the initial coverage criteria in effect at the time were met and the criteria for coverage after the first 3 months that were in effect at the time were met, the KX modifier may be added to claim with dates of service on or after November 1, 2008 as long as the patient continues to use the device.

**Beneficiaries Entering Medicare:**

For beneficiaries who received a PAP device prior to enrollment in fee for service (FFS) Medicare and are seeking Medicare coverage of either rental of the device, a replacement device or accessories, the supplier may add the KX modifier only if both of the criteria listed in the "Indications and Limitations of Coverage and/or Medical Necessity" for "Beneficiaries Entering Medicare" section have been met.

The supplier may hold claims, pending confirmation that the above requirements are met, and then submit claims with the KX modifier beginning with the date of FFS Medicare enrollment.

GA and GZ modifier

In all of the situations above describing use of the KX modifier, if all of the coverage criteria have not been met, the GA or GZ modifier must be added to a claim line for the PAP equipment and accessories. When there is an expectation of a reasonable and necessary denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Noncoverage (ANN) or the GZ modifier if they have not obtained a valid ANN.

Claim lines billed without a GA, GZ or KX modifier will be rejected as missing information.

**Power Mobility Devices**

If the requirements related to a face-to-face examination (see the Mobility Device (Non-Ambulatory) and Accessories reimbursement policy) have not been met, the GY modifier must be added to the codes for the power mobility device and all accessories.

If the power mobility device or push-rim activated power assist device that is provided is only needed for mobility outside the home, the GY modifier must be added to the codes for the item and all accessories. A KX modifier may be added to the code for a power mobility device and all accessories only if one of the following conditions is met:

- If all of the coverage criteria specified in the Mobility Device (Non-Ambulatory) and Accessories reimbursement policy have been met for the product that is provided; or
- If there is an affirmative Advance Determination of Medicare Coverage (ADMC) for the product that is provided.

If the requirements for use of the KX modifier or GY modifier are not met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter GA on the claim line if they have obtained a properly executed Advanced Notice of Noncoverage (ANN) or GZ if they have not obtained a valid ANN.

Claim lines billed without a KX, GA, GY, or GZ modifier will be rejected as missing information.

**Pressure Reducing Support Surfaces - Group 1**

Suppliers must add a KX modifier to a code only if all of the criteria in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the Pressure Reducing Support Surfaces reimbursement policy have been met and evidence of such is maintained in the supplier's files. This information must be available upon request.

If all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a denial as not reasonable and necessary, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Noncoverage (ANN) or the GZ modifier if they have not obtained a valid ANN.

Claim lines billed without a KX, GA, or GZ modifier will be rejected as missing information.
### Pressure Reducing Support Surfaces - Group 2

Suppliers must add a KX modifier to a code only if all of the criteria in the “Indications and Limitations of Coverage and/or Medical Necessity” section of the Pressure Reducing Support Surfaces reimbursement policy have been met and evidence of such is maintained in the supplier’s files. This information must be available upon request.

If all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a denial as not reasonable and necessary, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Noncoverage (ANN) or the GZ modifier if they have not obtained a valid ANN.

Claim lines billed without a KX, GA, or GZ modifier will be rejected as missing information.

### Pressure Reducing Support Surfaces - Group 3

Suppliers must add a KX modifier to E0194 on the initial claim only if all of the criteria in the “Indications and Limitations of Coverage and/or Medical Necessity” section of the Pressure Reducing Support Surfaces reimbursement policy have been met and evidence of such is retained in the supplier’s files and available to the DME MAC upon request.

For each subsequent month’s claim use a KX modifier only if the physician’s monthly certification indicates that continued use is necessary. Discontinue use of the KX modifier if the coverage criteria are not met or use is discontinued.

In all of the situations above describing use of the KX modifier, if all of the specific coverage criteria have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a denial as not reasonable and necessary, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Noncoverage (ANN) or the GZ modifier if they have not obtained a valid ANN.

Claims lines billed with codes without a KX, GA or GZ modifier will be rejected as missing information.

### Refractive Lenses

For anti-reflective coating (V2750), tints (V2744, V2745) or oversized lenses (V2780), if medical necessity is documented by the treating physician, the KX modifier must be added to the code. For polycarbonate or Trivex TM lenses (V2784), if they are for a patient with monocular vision, the KX modifier must be added to the code. The KX modifier may only be used when these requirements are met. When the KX modifier is billed, documentation to support the medical necessity of the lens feature must be available upon request.

For anti-reflective coating (V2750), polycarbonate or Trivex TM lenses (V2784), tints (V2744, V2745) or oversized lenses (V2780), if the coverage criteria have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a denial as not reasonable and necessary, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Noncoverage (ANN) or the GZ modifier if they have not obtained a valid ANN.

Claims lines for anti-reflective coating (V2750), tints (V2744, V2745), oversized lenses (V2780) or polycarbonate or Trivex TM lenses (V2784) billed without a KX, GA, or GZ modifier will be rejected as missing information.

### Respiratory Assist Devices

Proper use of modifiers is discussed below. Specific modifiers must be used and differ depending on whether or not the requirements outlined in the documentation section have been met.

Where permitted, KX must be added to codes E0470 and E0471 and codes for accessories used with E0470 and E0471. The KX modifier must not be used until the required documentation has actually been obtained and entered into the supplier’s files.

On claims for the first through third months, suppliers must add a KX modifier if all of the criteria for patients in Groups I-IV in the Indications and Limitations and/or Medical Necessity section of this policy have been met. If the requirements for the KX modifier are not met, the KX modifier must not be used.

On the fourth month’s claim (and any month thereafter), the supplier must add a KX modifier if all the “Initial Coverage” criteria in the Indications and Limitations and/or Medical Necessity section of this policy have been met and the treating physician’s signed and dated statement described in the Indications and Limitations and/or Medical Necessity above, has been obtained for the supplier’s files.

If the completed and signed Physician statement is not in the supplier’s files in time for submission of the
fourth or succeeding months’ claims, the supplier may still submit the claims, but a KX modifier must not be added. However, if the supplier chooses to hold claims for the fourth and succeeding months until the completed and signed forms are obtained, those claims may then be submitted with the KX modifier, so long as their answers indicate continued compliant use of and benefit from the therapy, according to the Indications and Limitations of Coverage and/or Medical Necessity section.

GA and GZ Modifiers:
In all of the situations above describing use of the KX modifier, if all of the coverage criteria have not been met, the GA or GZ modifier must be added to a claim line for the RAD equipment (E0470 or E0471) and accessories. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Noncoverage (ANN) or the GZ modifier if they have not obtained a valid ANN.
Claim lines billed without a GA, GZ or KX modifier will be rejected as missing information.

Speech Generating Devices

Suppliers must add a KX modifier to codes E2500 - E2512, and only if all of the coverage criteria in the “Indications and Limitations of Coverage and/or Medical Necessity” section of this policy have been met. If all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a denial as not reasonable and necessary, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Noncoverage (ANN) or the GZ modifier if they have not obtained a valid ANN.
Claim lines billed without a KX, GA, or GZ modifier will be rejected as missing information.

Therapeutic Shoes for Persons with Diabetes

Suppliers must add a KX modifier to codes for shoes, inserts, and modification only if the following criteria have been met:

1. The patient has diabetes mellitus; and
2. The certifying physician has documented in the patient’s medical record one or more of the following conditions:
   a. Previous amputation of the other foot, or part of either foot, or
   b. History of previous foot ulceration of either foot, or
   c. History of pre-ulcerative calluses of either foot, or
   d. Peripheral neuropathy with evidence of callus formation of either foot, or
   e. Foot deformity of either foot, or
   f. Poor circulation in either foot; and
3. The certifying physician has certified that indications (1) and (2) are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes. For claims with dates of service on or after 1/1/2011, the certifying physician must:
   a. Have an in-person visit with the patient during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts; and
   b. Sign the certification statement (refer to the Documentation Requirements section of the related Local Coverage Determination) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.
4. Prior to selecting the specific items that will be provided; the supplier must conduct and document an in-person evaluation of the patient. (Refer to the related Local Coverage Determination, Documentation Requirements section, for additional information.)
5. At the time of delivery of the items selected, the supplier must conduct and document an in-person visit with the patient.
This documentation must be available upon request. The Statement of Certifying Physician form is not sufficient to meet this requirement.
If criteria 1-5 in the Non-Medical Necessity Coverage and Payment Rules section of the related Policy Article have not been met, the GY modifier must be added to each code.
If a KX or GY modifier is not included on the claim line, it will be rejected as missing information.

Transcutaneous Electrical Nerve Stimulators
Suppliers must add a KX modifier to code E0731 only if all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section of this policy have been met. If all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a reasonable and necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Noncoverage (ANN) or the GZ modifier if they have not obtained a valid ANN. Claim lines billed for E0731 without a GA, GZ or KX modifier will be rejected as missing information.

### Urological Supplies

Suppliers must add a KX modifier to a code only if the order indicates the patient has permanent urinary incontinence or urinary retention, and if the item is a catheter, an external urinary collection device, or a supply used with one of these items. If all the criteria in the related Policy Article are not met, the GY modifier must be added to the code. Claims lines billed without a KX or GY modifier will be rejected as missing information.

### Walkers

If a heavy duty walker (E0148, E0149) is provided and if the supplier has documentation in their records that the patient's weight (within one month of providing the walker) is greater than 300 pounds, the KX modifier should be added to the code. If the above criterion has not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Noncoverage (ANN) or the GZ modifier if they have not obtained a valid ANN. Claims lines billed with codes E0148 - E0149 without a KX, GA, or GZ modifier will be rejected as missing information. See the [Mobility Devices (Ambulatory)](https://www.unitedhealthcare.com) reimbursement policy for additional information.

### Wheelchair Options/Accessories

For accessories for a power mobility device, if the requirements related to a 7-element order and face-to-face examination in the Mobility Device Reimbursement Policy have not been met, the GY modifier must be added to the codes for all accessories. For accessories provided with a manual wheelchair or power mobility device, if it is only needed for mobility outside the home, the GY modifier must be added to the codes for all accessories. If the conditions for use of the GY modifier are not met, the KX modifier must be added to the code for the accessory only if (a) the coverage criteria that are specified in the [Mobility Device (Non-Ambulatory) and Accessories](https://www.unitedhealthcare.com) reimbursement policy have been met and (b) any specific coverage criteria for the accessory in the [Mobility Device (Non-Ambulatory) and Accessories](https://www.unitedhealthcare.com) reimbursement policy have been met. If the coverage criteria are not met, the KX modifier must not be used. If the conditions for use of the GY modifier are not met and if the requirements for use of the KX modifier are not met, the GA or GZ modifier must be added to a claim line for the accessory. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Noncoverage (ANN) or the GZ modifier if they have not obtained a valid ANN. If the GY modifier is used, the KX, GA, and GZ modifiers should not be used. Claim lines billed without a GA, GY, GZ, or KX modifier will be rejected as missing information.

### Wheelchair Seating

For a skin protection seat cushion (E2603, E2604, E2622, E2623), a KX modifier must be added to the code only if either criterion (a), (b), or (c) is met:

- a. If there is a past history of or current pressure ulcer in the area of contact with the seating surface; or
- b. If there is absent or impaired sensation in the area of contact with the seating surface due to one of the diagnoses listed as a covered diagnosis; or
- c. If there is an inability to carry out a functional weight shift due to one of the diagnoses listed as a covered diagnosis.

For a positioning seat cushion (E2605, E2606), positioning back cushion (E2613-E2616), or positioning
accessory (E0956-E0957, E0960), a KX modifier must be added to the code only if the patient has significant postural asymmetries due to one of the diagnoses listed as a covered diagnosis. For a headrest (E0955), a KX modifier must be added to the code only if one of the coverage criteria specified in the Indications and Limitations of Coverage section has been met. For a combination skin protection and positioning seat cushion (E2607, E2608, E2624, E2625), a KX modifier must be added to the code only if criterion (a) or (b) or (c) is met and criterion (d) is met:

a. If there is a past history or current pressure ulcer in the area of contact with the seating surface; or
b. If there is absent or impaired sensation in the area of contact with the seating surface due one of the diagnoses listed as a covered diagnosis for skin protection cushions (except 707.03, 707.04, 707.05); or

c. If there is an inability to carry out a functional weight shift due one of the diagnoses listed as a covered diagnosis for skin protection cushions (except 707.03, 707.04, 707.05); and

d. If the patient has significant postural asymmetries due to one of the diagnoses listed as a covered diagnosis for positioning cushions.

For a custom fabricated seat or back cushion (E2609, E2617), a KX modifier must be added to the code only if criterion (a) is met and criterion (b), (c), or (d) is met:

a. For E2609 or E2617, there is a comprehensive written evaluation by a licensed/certified medical professional, such as a PT or OT (who has no financial relationship with the supplier) which explains why a prefabricated seating system is not sufficient to meet the patient's seating and positioning needs; and

b. For E2609, there is a past history of or current pressure ulcer in the area of contact with the seating surface; or

c. For E2609, there is absent or impaired sensation in the area of contact with the seating surface or an inability to carry out a functional weight shift due to one of the diagnoses listed as a covered diagnosis for skin protection cushions; or

d. For E2609 or E2617, the patient has significant postural asymmetries due to one of the diagnoses listed as a covered diagnosis for positioning cushions.

In addition to meeting the specific requirements listed above, for all seat and back cushions and positioning accessories, the KX modifier must be added to the code only if the item is being used with a wheelchair that meets coverage criteria specified in the Mobility Device Reimbursement Policy. GA, GY, AND GZ Modifiers:

For a cushion or positioning accessory that is used with a power mobility device, if the requirements related to a 7-element order and face-to-face examination in the Mobility Device (Non-Ambulatory) and Accessories reimbursement policy have not been met, the GY modifier must be added to the codes for all items.

For items provided with a manual wheelchair or power mobility device, if it is only needed for mobility outside the home, the GY modifier must be added to the codes for all items.

In all of the situations above describing use of the KX modifier, if all of the specific coverage criteria have not been met or if the wheelchair that it is being used with does not meet the coverage criteria in the Mobility Device (Non-Ambulatory) and Accessories reimbursement policy, the GA or GZ modifier must be added to a claim line for the seat or back cushion or positioning accessory. When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advanced Notice of Noncoverage (ANN) or the GZ modifier if they have not obtained a valid ANN.

If the GY modifier is used, the KX, GA, and GZ modifiers should not be used. Claim lines billed without a GA, GY, GZ, or KX modifier will be rejected as missing information.
Attachments: Please right-click on the icon to open the file

| UnitedHealthcare Community Plan Procedure to Modifier List | A list of HCPCS codes with corresponding allowable modifiers |

Resources

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

History

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<th>Change Details</th>
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<tr>
<td>3/8/2017</td>
<td>Policy Approval Date Change (no new version)</td>
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<td>1/1/2017</td>
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<tr>
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<td>Reimbursement Guidelines; Removed reference to ICD-9-CM</td>
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<td>Attachments; The UnitedHealthcare Community Plan Procedure to Modifier List was updated with the new version</td>
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<td>Pneumatic Compression Devices (Still in Draft stage as of 07/25/2012)-removed as this doesn't require a KX modifier.</td>
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<td>Attachment section:</td>
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<td>Code list updated</td>
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<td>5/1/2015</td>
<td>History Section: Corrected revision statement made to the Application Section on 3/1/2015</td>
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<td>3/11/2015</td>
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<td>Approved By Section: Replaced UnitedHealthCare Community &amp; State Payment Policy Committee with Payment Policy Oversight Committee</td>
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