Anthem Blue Cross

Medicare Advantage Reimbursement Policy Provider Bulletin

December 2016

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member’s Anthem benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member’s state of residence. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, we strive to minimize these variations. For more information on these and other Anthem Reimbursement Policies, click here.

New Policy

Corrected Claims
(Policy 16-001, effective 05/15/2017)

Anthem allows reimbursement for a Corrected Claim when received within 12 months during the timely filing period for participating and nonparticipating providers and facilities.

Providers resubmitting paper claims for corrections must clearly mark the claim “Corrected Claim.” Corrected Claims submitted electronically must have the applicable frequency code. Failure to mark the claim appropriately may result in denial of the claim as a duplicate.

Note: Corrected Claims must be submitted separately for each member and episode of care and cannot be accepted by batch, bulk, or packaged submissions.

For additional information, refer to the Corrected Claims reimbursement policy at www.anthem.com/ca/medicareprovider.

Policy Update

Modifier Usage
(Policy 06-006, effective 08/01/16)

Reimbursement for covered services provided to eligible members when billed with appropriate procedure codes and appropriate modifiers is based on the code-set combinations submitted with the correct modifiers. The use of correct modifiers does not guarantee reimbursement. The use of certain modifiers requires the provider to submit supporting documentation along with the claim. In the absence of state-specific modifier guidance, we will default to CMS guidelines.
Refer to the Exhibit A: Reimbursement Modifiers Listing for descriptions and guidance on documentation submission. For additional information, refer to the Modifier Usage reimbursement policy at www.anthem.com/ca/medicareprovider.

Policy Reminder

**Multiple Radiology Payment Reduction**  
*(Policy 11-005, originally effective 01/01/2015)*

Anthem allows reimbursement for multiple diagnostic imaging procedures including CT, MRA, MRI, and Ultrasound. These procedures will be subject to a Multiple Procedure Payment Reduction (MPPR) when services are performed by the same physician, health care professional, or physicians in the same group practice with the same National Provider Identifier (NPI) on the same date of service during the same patient encounter. The global service and Technical Component (identified by adding Modifier TC) of certain diagnostic imaging procedures will reimburse at:
- 100 percent of the physician fee schedule or negotiated amount for the service with the highest Technical Component payment
- 50 percent for the Technical Component of subsequent services furnished by the same physician or physicians in the same group practice to the same patient in the same session on the same day

Refer to the Multiple Radiology Payment Reduction reimbursement policy at www.anthem.com/ca/medicareprovider.

**Split-Care Surgical Modifiers**  
*(Policy 11-005, effective 08/01/16)*

Reimbursement of surgical codes appended with “split-care modifiers,” is allowed and based on a percentage of the fee schedule or contracted/negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code:
- Modifier 54 (surgical care only): 80 percent
- Modifier 55 (postoperative management only): 20 percent

Included in the global surgical package are preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's care. Claims received with split-care modifiers after a global surgical claim is paid will be denied. Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

For more information, refer to the Split-Care Surgical Modifiers reimbursement policy at www.anthem.com/ca/medicareprovider.