Introducing our two new Senior Network Service Specialists!
The Network Management team is excited to introduce two new Senior Network Service Specialists! Gayle Burstein and Dave Dickinson recently joined our team in late April to compliment the Provider Contracting Team. They will be handling provider relations for our professional providers throughout the state. Gayle will be handling the northern part of the state, Dave will handle the southern, and they will be splitting the Denver metro area. Both have been added to the attached Escalation Contact List, listed under the Network Management team. Please continue to contact your Contracting Representative for contract related issues, including pricing and demographic type updates that are related to your contract. To obtain a copy of the current Escalation Contact List, go to anthem.com. Select Providers, Colorado and enter. Under the Communications tab, select Contact Us. Then select the Escalation Contact Link.

New Cost Containment dedicated customer service unit
Members and providers can now receive Cost Containment customer service support by calling 303-861-1449, Monday through Friday, 8:30 a.m. to 4:30 p.m., PST.

This number connects you to a small customer service unit dedicated to overpayments for local member claims only. (All BlueCard or FEP overpayment requests should be routed to the customer service unit respectively.) The Cost Containment Customer Service (for Local member claims) assists:

- Callers with overpayment issues resulting from overpayment letters.
- Providers in balancing their books when “clipping” (or the automatic take back) has occurred.

For all other claims status, eligibility, or benefit requests, please contact our regular customer service unit. (The new Cost Containment unit has also been added to the Escalation Contact List which is posted at anthem.com. See directions in article above to download a copy.)

New alpha prefixes for local Colorado members
DNU, IMW, KOS, NQG, PKV, TGZ, TIV, TZX, UCL, and XFE are new alpha prefixes that identify local Colorado members in addition to the traditional XF alpha prefixes. Please note that any members with one of these custom alpha prefixes will be serviced the same as our other local members. This information, along with the other existing custom alpha prefixes, has been added on the Alpha Prefix Reference List. To obtain a copy of the current Alpha Prefix Reference List, go to anthem.com. Select Providers, Colorado and enter. Under the Communications tab, select Contact Us. Then select the Alpha Prefix Reference List link.

Claims editing system updated
Our claims editing system is updated at least once and sometimes twice a year. We updated our claims editing system on May 10, 2008 with ClaimCheck Version 41 edits (e.g., incidental, mutually exclusive and rebundle edits). Updates to the post-operative aftercare days assigned by The Centers for Medicare & Medicaid Services (CMS) were also done. The edit changes apply to applicable 2008 CPT® and HCPCS® codes (existing and new). In each
revision, auditing criteria is reviewed and updated based on new codes, current healthcare trends, CMS guidelines, AMA guidelines, Specialty Society Guidelines, CPT Assistant review and medical and technological advances. These changes will be reflected on claims processed on and after May 10, 2008. Claims processed after that date, regardless of date of service, will be subject to the edit update.

Local Customer Service now requesting callers first and last name
To better serve our providers, Customer Service will now be requesting a caller’s first and last name. This will provide us better contact information in the event that we need to follow up with the caller. If the caller does not want to provide a full last name, a first name and initial of last name will be helpful, as well.

Good Samaritan Medical Center joining the Anthem networks effective July 1, 2008
Effective July 1, 2008, Good Samaritan Medical Center will join the other Exempla Healthcare facilities as being in-network for Anthem’s HMO, PPO and Indemnity products.

Coding for nerve conducting studies
It’s important to follow coding and billing guidelines when submitting claims for nerve conduction studies for CPT® procedure codes 95900 (nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study), 95903 (motor, with F-wave study) and 95904 (sensory).

The following explanation of the coding guideline for nerve conduction studies was published in the March 2005 edition of the *CPT® Assistant*.

**Question:** Is it appropriate to report multiple units of code 95900, nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study, when multiple sites on the same nerve are stimulated or recorded?

**AMA Comment:** Within the CPT® codebook 2007, the parenthetical note following code 95904 states: Report 95900, 95903, and/or 95904 only once when multiple site on the same nerve are stimulated or recorded.

“When nerve conduction studies are performed on two distinct branches of a given motor or sensory nerve in which both stimulating and recording electrodes are moved to different locations, then it is appropriate to report more than one code from the 95900-95904 series of codes. See CPT® Assistant March 2005, Page 17 for further details.”

Therefore when billing for multiple units for the above three codes, you may only bill for one unit when multiple sites on the same nerve are stimulated or recorded. If either the stimulating electrode or the recording electrode was moved, but not both, you cannot bill for an additional unit, and should not be billing for procedure code 95900, 95903, 95904 with a modifier-59. In cases where both electrodes are moved, you should report that codes on a separate line, with modifier-59, and any additional units on that claim line.

Please also refer to Appendix J of the American Medical Association CPT® 2007 book, which also discusses proper billing of units, as well as a table providing for a reasonable maximum number of studies necessary for a physician to arrive at a diagnosis.
Finally, we’d like to take this opportunity to inform you that quantitative sensory testing (QST) including, but not limited to current perception threshold testing, also known as sensory nerve conduction threshold testing, and pressure-specified sensory device testing is considered investigational/not medically necessary per Anthem Medical Policy MED.00082. These procedures should not be billed with CPT® codes 95900, 95903, 95904, 95937. Please refer to the appropriate unlisted code for billing of these services.

Understanding electronic filing options

If you are considering electronic claims filing, there are several options available, and the services and connection options vary by the method you select. In our ongoing efforts to make it easier for you to do business with Anthem Blue Cross and Blue Shield, we are including information that outlines options available and how these approaches can best support your practice or facility. We hope you find the information helpful.

You can use electronic vendor or the direct submission approach when filing electronic transactions through the electronic data interchange (EDI) process to Anthem Blue Cross and Blue Shield. While EDI vendors offer varying levels of service, many provide additional services to suit your needs, including the software and hardware needed to automate your office with electronic solutions such as:

- Crossovers
- Electronic remittance advices (ERA)
- Real time eligibility and claim status

Anthem Blue Cross and Blue Shield does not charge a fee to submit electronically. We contract with clearinghouses, software vendors and direct submitters to help ensure provider satisfaction, as well as timely and accurate processing of transactions. Regardless of the submission method, you should be familiar with the Health Insurance Portability and Accountability Act (HIPAA) claim requirements and the type of claims that can be submitted electronically.

Clearinghouses:

- Contract directly with individual providers to submit claims electronically for a fee while ensuring compliance with HIPAA and Anthem Blue Cross and Blue Shield requirements.
- May install software compatible with most providers’ practice management systems, allowing providers to submit transactions electronically to the clearinghouse.
- Route the providers’ submission to Anthem Blue Cross and Blue Shield, Medicare/Medicaid or commercial carriers.
- Work directly with payers and submit transactions electronically on behalf of the provider.
- Monitor EDI submissions and payer communications for system upgrades, installing payer front-end edits as appropriate.
- Manage the payer relationship and connectivity, working directly with payers to submit, receive and troubleshoot transactions and reports.
- Provide customer support, training, daily reports, automated remittance advice posting and claim error corrections and re-submission capabilities, helping to ensure timely delivery and pick-up of electronic transactions and reports.

While a clearinghouse handles most of the EDI services related to the providers’ electronic submissions, you should have staff available to troubleshoot submission issues, review/resolve the reports daily from the clearinghouse and correct/re-submit claims in error.
Software Vendors:
- Develop, maintain, sell and install software that allows providers to submit directly. Providers opting for the direct submission approach will contract directly with the payer. With this approach, the provider works with the payer to submit, receive and troubleshoot transactions and reports.
- In some instances, providers will use software vendors who may route submissions to the designated payers – such as Anthem Blue Cross and Blue Shield, Medicare/Medicaid or commercial carriers – for the provider. With this approach, the provider works with the vendor to submit, receive and troubleshoot transactions and reports.
- Provide support for payer registration, testing connectivity and HIPAA compliance. Other software vendor services include customer support, training, daily reporting, automated remittance advice posting, claim error correction, and re-submission functionality.
- Ensure compliance with HIPAA requirements installing system modifications as needed.

If selecting electronic submission using vendor software or opting to submit directly, you should have staff knowledgeable about their EDI processes as this is a more self-sufficient approach.

Billing Agencies:
- Contract directly with the provider and perform various EDI-related services on behalf of the provider, for a fee.
- Receive claims from the provider on paper or electronically and then submits the claims directly to Anthem Blue Cross and Blue Shield, Medicare/Medicaid or commercial carriers.
- Manage the payer relationship and connectivity, while monitoring payer communications for system upgrades and maintaining HIPAA certification and compliance.
- Pick up and deliver or post all files and reports, reconciling the EDI submissions while monitoring reports and making the necessary claim corrections and re-submissions.
- Work directly with payers to submit, receive and troubleshoot transactions and reports on behalf of clients.
- May manage the provider’s accounts receivables, including collections of past due accounts.

If selecting a billing agency, there can be little to no involvement in the EDI submission process, you should consult with the billing agency to evaluate and select the services they wish to receive.

Please contact the vendors, billing agencies or clearinghouses directly for more information on their products and/or services. Visit our website for a list of clearinghouses, software vendors and billing agencies submitting electronic transactions to Anthem Blue Cross and Blue Shield.

Contacting Us:
If you have questions regarding electronic filing please contact an Anthem Blue Cross and Blue Shield EDI Solutions Specialist at:

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