Anthem BlueCross BlueShield

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Network Update

CENTRAL REGION

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**Notice of Material Changes to Contract may apply.*

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IN, KY, MO, OH, WI

Professional Reimbursement Claims Editing Notifications

Summary

Anthem Blue Cross and Blue Shield of Indiana, Kentucky, Missouri, Ohio and Wisconsin (hereafter known as the Health Plan) currently utilizes a proprietary, comprehensive, nationally recognized code auditing system to ensure consistent provider reimbursement by automatically evaluating provider claims in accordance with, but not limited to, our professional reimbursement policies, industry standard guidelines, coding guidelines developed by national medical specialty societies, and correct coding guidelines as documented in Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS Level II), the Centers for Medicare & Medicaid Services National Correct Coding Initiative (NCCI), plus International Classification of Diseases (ICD) 9 and 10.

This notice is to advise providers that during the timeframe of September 11, 2015 through October 12, 2015, the Health Plan will phase in claim editing systems such as McKesson Inc.'s ClaimsXten® along with another proprietary auditing system that will automatically apply new or existing edits. These claims editing systems are based on industry standards, including, but not limited to, NCCI, American Medical Association (AMA)/CPT, HCPCS, national specialty societies, physician consultant reviews, vendor physician reviews, and Health Plan guidelines, policies, and procedures.

These editing systems will allow Anthem to administer claim edits automatically that previously may have required manual intervention or retroactive claim adjustments, achieve consistency with nationally accepted coding guidelines, and facilitate accurate, efficient claims processing. These edits will be effective for claims with dates of service on or after September 11, 2015 unless otherwise indicated.

A product of McKesson, Inc., Clear Claim Connection™, will be available for Federal Employee Program® (FEP) claims, as well as for various commercial claims. This tool will enable providers to prescreen code combinations for edits and retrospectively inquire on edits for those claims that apply ClaimsXten rules.

Some of the following edits currently exist on our local editing systems and are identified in our Claim Editing Overview Policy. Effective September 11, 2015, revised Explanation of Benefits (EOB) codes may be applied with the implementation of our new editing systems.

In the Addendum to this document, we have included examples of the new edits that will be effective for September 11, 2015 (indicates process date or date of service).

Note: The following professional reimbursement claims editing notifications may include a potential impact and are listed alphabetically so that you more easily can locate the relevant policy/coding edit online. Under the title of each notification, blue text indicates if this is a change in policy, claim edit or something else. Please note that the section, Revised Other Policies, includes a list of other policies with minor edits/changes that do not materially impact reimbursement.

After Hours, Emergency, and Miscellaneous E/M Services
-- Professional reimbursement policy update

In our policy dated September 11, 2015, we have clarified our position regarding holidays. The Health Plan does not designate a special status for holidays. If a holiday falls on a weekday, then services rendered between 5:00 p.m. and 8:00 a.m. on that day are eligible for after-hours reimbursement. If a holiday falls on a weekend day, then services rendered anytime during the weekend are eligible for after-hours reimbursement. In addition, CPT code 99050 is not eligible for separate reimbursement when it is reported with a preventive diagnosis and/or a preventive service.

Age to Diagnosis
-- Custom claim edit for ICD-9-CM or ICD-10-CM

This edit identifies when an age-specific diagnosis code is reported for a patient whose age is outside the designated age range for that diagnosis. Codes with an age edit are identified in ICD-9-CM or ICD-10-CM by one of the following symbols to the right of the code description:

N = Newborn age: 0 years
P = Pediatric age: 0-17 years
M = Maternity age: 12-55 years
A = Adult age: 15-124 years

Example: When a provider submits a procedure for a 25 year-old patient with diagnosis code 058.11—Roseola Infantum due to Human Herpes virus 6 which is valid for ages 0-17, the editing system identifies that the patient age does not coincide with the age description of the diagnosis; therefore, the claim line will not be eligible for reimbursement due to age to diagnosis restriction.

Assistant Surgeon
-- Updates to current professional reimbursement policy

1) Indiana and Missouri: For claims processed on or after September 11, 2015, Assistant Surgeon services reported with modifier AS will be eligible for reimbursement under the applicable fee schedule at 16% of the maximum allowance for the primary procedure. Multiple surgery reimbursement rules are applied to subsequent procedures, if applicable.

2) Kentucky, Ohio, and Wisconsin: For claims processed on or after September 11, 2015, Assistant Surgeon services reported with modifiers AS will be eligible for reimbursement under the applicable fee schedule at 14% of the maximum allowance for the primary procedure. Multiple surgery reimbursement rules are applied to subsequent procedures, if applicable.

Note: Annual review of the language that does not affect the outcome of the reimbursement for claims submitted was updated throughout the policy.

Bundled Services and Supplies
– Professional reimbursement policy changed by additional editing and revised language

Editing for this policy is based on sources including, but not limited to, CMS, NCCI, CPT and HCPCS instructions and guidelines, and Health Plan policy.

Examples of updates to Section 1 (Services and supplies not eligible for separate reimbursement) and Section 2 (Procedures, services, and supplies not eligible for separate reimbursement when reported with another specific procedure, service, or supply) may be found in the Addendum.

- Example: Section 1 will include CPT codes 99487 and 99498 (advanced care planning). The Health Plan considers this service be part of the overall patient care and management.

- Example: Section 2 will include that column chromatograph/mass spectrometry non-drug analyte testing services (codes 82541 – 82544) will not be eligible for separate reimbursement when reported with drug screening or definitive drug testing services (codes 80300, 80301, 80302, 80303, 80304, 80320 – 80377. This is based on CPT instructions.

Note: Many of the code to code edits are also identified in our Modifiers 59 and XE, XP, XS, & XU (Distinct Procedural/Separate/Unusual Service) reimbursement policy.

In addition, our new editing systems will automatically apply the edits currently described in Section 3 (Services not eligible for separate reimbursement when reported with any other procedure, service, or supply) of our policy.

Correct Coding Initiative Rules
– Reminder that this is in current claim editing overview policy

This rule identifies the CMS (Centers for Medicare and Medicaid Services) NCCI edits. NCCI edits may be reviewed by visiting: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html.

NCCI edits consist of those edits listed in the CMS Column One/Column Two Correct Coding edit file (formerly, the comprehensive/component edits). Column One in this edit file represents allowed codes; Column Two represents denied codes. CMS no longer publishes a separate Mutually Exclusive edit file. The edits previously contained in the Mutually Exclusive edit file have not been deleted but have been moved to the Column One/Column Two Correct Coding edit file.

Non-site specific modifiers include 24, 25, 57, 58, 59, 78, 79, 91, XE, XP, XS, and XU and:

- may override an NCCI edit with a superscript of 1 when appended to a code listed in column 2, making the column 2 code eligible for separate reimbursement.

- will not override an NCCI edit with superscript of 0 when appended to a code listed in column 2 and therefore the column 2 code is not eligible for separate reimbursement.

NCCI edits will be applied to code pairs which, under our other reimbursement rules (such as procedure unbundling), might be eligible for separate reimbursement but under NCCI edits are considered incorrect coding. Therefore, such code pairs are not eligible for separate reimbursement. NCCI edits will be adjudicated after the unbundling edits have been completed.

Duplicate Reporting of Diagnostic Services
– New professional reimbursement policy

The Health Plan will post a new policy titled "Duplicate Reporting of Diagnostic Services." When the ordering provider and the provider who actually performed the diagnostic services both report the same CPT/HCPCS code for the same patient on the same date of service, only the first claim processed will be eligible for reimbursement. Our claim editing systems will consider subsequent claims from any provider reported for the same diagnostic services for the same patient on the same date of service to be a duplicate service and the subsequent same service will not be eligible for separate reimbursement.

Example: When the ordering provider sends a specimen to the laboratory, and the ordering provider and the laboratory both report the same CPT or HCPCS code, only the first claim processed will be eligible for reimbursement. This will also apply to those times when one provider reports a global diagnostic service and another provider reports a component of the diagnostic service (either the technical component or the professional component), only the first claim processed will be eligible for reimbursement and subsequent claims with the same procedure code, with or without modifiers, will be denied as duplicate services.

Durable Medical Equipment
– Reminder of current professional reimbursement policy

For claims processed on or after September 11, 2015, our editing systems will automatically apply the following Health Plan policy guidelines:

1) Identify rental vs. purchase
2) Track the number of months an item has been rented (max 10 month rental)
3) Look at modifiers to determine if purchase or rental (modifiers are required to determine if item has been rented or purchased)
4) Identify items that are or are not eligible for repair or maintenance

Minor word changes were made to the policy language; however, they do not change the policy position or criteria.

Frequency Editing
– Updates to current professional reimbursement policy

- Base Code Quantity: Identifies a claim reporting a primary service with a base-code that has a quantity greater than one, rather than reporting the appropriate add-on code. We are strengthening when the line item with the base code quantity greater than one will be denied and replaced with a line item that allows payment for only one procedure. This edit also identifies multiple occurrences of a base code reported on separate lines. The additional base code line item(s) will not be eligible for reimbursement. See CPT Appendix D for the list of add-on codes.

  Example single line, multiple units: Base procedure code 63102 – vertebral corpectomy lumbar, single segment – is submitted with a quantity of three and no other line on the same claim or in the claim history. The editing system will recommend that only one unit will be eligible for reimbursement.

  Example multiple lines: Base procedure code 63102 – vertebral corpectomy lumbar, single segment – is reported on three separate lines for the same date of service. Only one occurrence of procedure 63102 is allowed and the other two occurrences will not be eligible for reimbursement.

- Frequency/Maximum Units: Identifies when a procedure code is reported either more than once per date of service or across dates of service, which exceeds the number of times its verbiage indicates, or when it exceeds the number of times it is clinically appropriate or clinically possible to perform.

  Example: When a provider reports procedure code 95165 more than 120 units within a 365 day period, our editing systems will only allow 120 units within that time period.

  Example: When a provider reports procedure code 90378 with more than four units on a date of service, our editing systems will only allow four units for that date.

- Frequency/Maximum Occurrences per Code Group: Identifies when procedures within a code grouping are reported more than the once per date of service in any combination, our editing systems will allow one service within the grouping.

  Example: Routine blood collection codes 36415, 36416, and S9529 are considered to be the same service; therefore, when all of these codes are reported on the same date of service by the same provider for the same patient, only one of the procedures will be allowed for that date of service.

- Our current Frequency Editing logic limits CPT code 96401 to one unit when reported for the administration of Xolair® and a diagnosis of asthma. We will be adding the diagnosis of idiopathic urticaria to this edit. Xolair® is a very viscous drug and only 150 mg maximum can be administered per injection site. Since the patient's dosage is based on his/her weight, it may require more than one injection for the correct dosage to be administered. The intent of the RVU weighting of CPT code 96401 is for the patient risk and the direct practice expense per dose, not the number of syringes and injections needed to deliver the correct dose; therefore, this limit is based on the "per dose" administration of Xolair® for any approved diagnosis.

Global Surgery
– Updates to current professional reimbursement policy

- Non-physician providers (NPPs), including but not limited to, physician assistants (PAs) and nurse practitioners (NPs, APRNs, etc.) in the same group as the surgeon are considered to be of the same specialty as the surgeon.

- Fluid and drug administration services such as therapeutic, prophylactic, and/or local anesthetic injections (e.g., J2001 and 96372) are included in the global surgical package.

- Our systems enhancements will now assess the appropriate billing of surgical services rendered by multiple providers, ensuring modifiers 54, 55, 56, 76, 77, 78, 79 have been reported accurately.

- Strengthening our preoperative and postoperative edits which identify E/M visits that are reported one day prior to a 90-day surgical procedure or during the 10 or 90-day aftercare period. When the E/M code is reported within the global surgery period, then the E/M code will not be eligible for reimbursement and will be denied as part of the global surgical reimbursement.

- When the claim editing system detects surgical supplies reported by the same provider on the same date of service as a 0-day, 10-day, or 90-day surgical procedure, the surgical supplies will not be eligible for separate reimbursement.

Health and Behavioral Assessment/Intervention
– Updates to current professional reimbursement policy

- CPT code 96155 will not be eligible for reimbursement since the service is not a face-to-face encounter with the patient.

- Our claim editing systems will apply a frequency limit of 8 units per date of service for CPT codes 96150-96154.

- Annual review of the language that does not affect the outcome of the reimbursement for claims submitted was updated throughout the policy.

Injection and Infusion Administration and Related Services and Supplies
– Updates to current professional reimbursement policy

Our claim editing systems for CPT code 96367 (additional sequential IV infusion up to one hour, in addition to the code for the primary procedure) will apply a frequency limit of six units per date of service.

Laboratory and Venipuncture Services
– Updates to current professional reimbursement policy

We will be adding an edit that the Health Plan's total reimbursement for individual laboratory codes that are part of a comprehensive blood panel/complete blood count (CBC) code will not exceed the allowance for such comprehensive blood panel/CBC code.

- When the Health Plan receives a claim for two or more of the individual laboratory procedure codes that are part of a comprehensive blood panel/CBC code, our claim editing systems will bundle those separate tests together into the appropriate comprehensive blood panel/CBC code. The comprehensive blood panel/CBC code will be added to the claim regardless of whether or not the provider bills all of the individual codes that make up the comprehensive blood panel/CBC code.

- The laboratory comprehensive blood panel/CBC code will be eligible for reimbursement, and the individually reported codes will be denied.

- When CMS National Physician Fee Schedule Relative Value File (NPFSRVF) designates that modifier 26 is applicable to a procedure code (PC/TC indicator of 1 or 6), and the procedure (e.g., laboratory) has been reported by a professional provider with a facility place of service, the procedure code must be reported with modifier 26 or it will not be eligible for reimbursement.

- When the NPFSRVF designates that the concept of a separate professional and technical component does not apply to a laboratory procedure (PC/TC indicator of 3 or 9), and a professional provider has reported the laboratory procedure code with a modifier 26, the laboratory procedure code will not be eligible for reimbursement. When a laboratory procedure with a PC/TC indicator of 3 or 9 is reported by a professional provider with a facility place of service, the laboratory procedure code will not be eligible for reimbursement since, in this case, the facility will bill for performing the laboratory procedure.

- When a professional provider bills the global code (no modifiers) with a facility place of service, the code will not be eligible for reimbursement.

- When one provider reports a global procedure and a different provider reports the same procedure with a professional component (26) or a technical component (TC) modifier, only the first charge processed as approved by the Health Plan will be eligible for reimbursement and the subsequent charge processed will not be eligible for separate reimbursement.

- Routine venipuncture CPT code 36415, and Healthcare Common Procedure Coding System (HCPCS Level II) S9529 and capillary blood collection code 36416, are eligible for separate reimbursement when reported with an E/M and/or a laboratory service. Unless an additional routine venipuncture/capillary blood collection is clinically necessary, the frequency limit for any of these services is once per member, per provider, per date of service. The frequency limit will also apply to any combination of these codes reported on the same date of service for the same member by the same provider. (See also our Frequency Editing Reimbursement Policy.)

- We are adding information to our policy that HCPCS code G0471 for the collection of venous blood by venipuncture or urine sample by catheterization from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency (HHA), collected by a laboratory technician that is employed by the laboratory that is performing the test, will be eligible for separate reimbursement when reported with a laboratory service.

- We are adding the following language to our policy (2014 CPT coding guidelines which state that CPT codes 36591and 36592 should not be reported "...in conjunction with other services except a laboratory service.2" Therefore, CPT codes 36591 and 36592 are only eligible for separate reimbursement when reported with a laboratory service) that may be referenced in our Bundled Services and Supplies Reimbursement Policy.

Modifier Rules
– Updates to current professional reimbursement policy

- Surgical services reported with modifier SA will not be eligible for reimbursement.

- Services billed with modifier XE, XP, XS, & XU will be processed in accordance with the Health Plan's reimbursement policy for Modifiers 59 and XE, XP, XS, & XU (Distinct Procedural Service).

- Annual review of the language that does not affect the outcome of the reimbursement for claims submitted was updated throughout the policy.

Modifier 59 and XE, XP, XS & XU (Distinct Procedural/Separate/Unusual Service)
– Updates (and new text) to current professional reimbursement policy

- Please note that effective January 1, 2015, CMS has created four new HCPCS "X" modifiers that will selectively identify subsets of modifier 59 for Distinct Procedural Services. As of January 1, 2015, we will apply edits to the –X modifiers, collectively referred to as X {EPSU}, equivalent to our modifier 59 edits. **More information on implementation of new modifiers will be communicated in the August 2015 issue of *Network Update.***

- In addition, modifier 59 will not allow for separate reimbursement for the first code(s) listed in a code to code relationship. For examples of new code to code edits, refer to the Addendum.

Multiple and Bilateral Surgery Processing
– Updates to current professional reimbursement policy

- Standard Multiple Surgery Reimbursement: Primary and subsequent procedures for standard multiple surgery reimbursement rules will be determined by the current highest relative value unit (RVU) rather than the highest maximum allowance. Therefore, 100% of the maximum allowance for the procedure with the highest Relative Value Unit (RVU) for the place of service and date of service and 50% of the maximum allowance for each subsequent procedure may be eligible for separate reimbursement. Standard multiple surgery reimbursement will also apply when a single procedure code is reported with multiple units on a single line.

- Multiple Endoscopies: Identifies multiple endoscopic surgical procedures within the same family that are subject to multiple surgery reimbursement rules. Endoscopic surgical procedures in the same base family will be reimbursed at 100% of the maximum allowance for the primary procedure and at a lower percentage for each subsequent procedure based on the Health Plan's Multiple Surgery policy. This will only happen when both endoscopic procedures are performed at the same operative session, with the same endoscopic base code as defined by CMS.

Code examples (see policy for additional code information):

Base Family	Codes	Percentages
Shoulder arthroscopy	29805---29825, 29827---29828	100% primary; 30% subsequent
Hip arthroscopy	29860---29863, 29914—29916	100% primary; 25% subsequent
Esophogogastroduodenoscopy (EGD)	43233, 43235---43259, 43266, 43270	100% primary; 25% subsequent

- Bilateral Surgical Billing: When two claim lines are submitted with the same procedure (unilateral) code, and one line (or both lines) has been reported with modifier 50 or modifier RT/LT, the Health Plan will treat the following coding scenarios as bilateral and apply standard multiple surgery reimbursement rules (100% of the maximum allowance for the first service and 50% for the second service):
    - One line with modifier LT and a second line with modifier RT, same procedure code—each line will be eligible for reimbursement at 75% (75% x 2 = 150%) of the amount applicable to such procedure code.
    - A single line, no modifier 50, quantity = 2— we will apply the guidelines described above related to bilateral surgeries that use a unilateral code.
    - When two claim lines are reported with the same procedure code and one line is reported with modifier 50 and the second line is unmodified, we will deny the two claim lines and combine them and their charges into one line with modifier 50 and apply the guidelines described above related to bilateral surgeries that use a unilateral code.
    - When two claim lines are reported with the same procedure code and both lines are reported with modifier 50, we will deny the two claim lines and combine them and their charges into one line with modifier 50 and apply the guidelines described above related to bilateral surgeries that use a unilateral code.

Multiple Diagnostic Imaging
– Updates to current professional reimbursement policy

- When two or more imaging procedures with an MPI of 4 are performed during the same imaging session and reported as technical component (TC) only, reimbursement is 100% of the maximum allowance for the first imaging procedure with the highest Relative Value Unit (RVU) for the date of service, and 50% of the maximum allowance for each subsequent imaging procedure for that date of service that has an MPI of 4.

- When two or more imaging procedures with an MPI of 4 are reported as global imaging procedures, our claims editing system will determine the primary imaging procedure based on the global RVUs for the date of service. Such primary imaging procedure will be eligible for 100% of the maximum allowance for that procedure. For all other imaging procedures with an MPI of 4 rendered on that date of service that are reported globally, our claim editing system will identify the technical component (TC) RVU and professional component (26) RVU separately for each such procedure and calculate eligible reimbursement as follows:
    - the technical component RVU will be reduced by 50%.
    - the professional component RVU will remain at 100%.
    - these two values are added together to obtain a new RVU value to be used in the calculation.
    - the new RVU value is then divided by the original total global RVU and multiplied by 100 to determine what percent of the global value is to be applied to such imaging procedures.
    - the original fee schedule global allowance is then multiplied by this new percentage value (which is rounded up) to determine the maximum allowance for such imaging procedure with an MPI of 4.

Below is an example of this calculation formula for all other global imaging procedures with an MPI of 4 that would be subject to the technical component reduction. For this example, we are using an original total RVU of 6.93 and an original global maximum allowance amount of $500.00. (-- technical component RVU = 5.46, -- professional component RVU = 1.47)

> The technical component RVU is reduced by 50%: 5.46 x .50 = 2.73 (new RVU for the technical component).
100 % of the professional component RVU is added to the new RVU for the technical component: 1.47 + 2.73 = 4.2 (new global RVU).
> The new global RVU (4.2) is divided by the original global RVU (6.93): 4.2 ÷ 6.93 = 0.6060.
> The result is then multiplied by 100 to obtain the final calculated payment percentage to apply to the global imaging procedure maximum allowance to be reduced: 0.6060 x 100 = 60.60%; payment percentages must be in full percentages therefore the 60.60% is rounded up to 61%.
> The maximum global allowance for the procedure is multiplied by the final calculated payment percentage to arrive at the final maximum allowance: $500.00 x 61% = $305.00.

- Multiple imaging reimbursement rules will also be applied to the technical component of eligible radiology codes if modifiers 76 or 77 (repeat procedure) are reported. These modifiers do not indicate to the Health Plan that the repeat procedure was performed as a distinct procedural service at a separate session/encounter.

Multiple Evaluation and Management Services and Related Modifiers -25 & -27
– Updates to current professional reimbursement policy

Based on Health Plan policy, only one Evaluation and Management (E/M) service is allowed per day. The Health Plan will not accept modifier 25 when it is reported by the same provider on the same day for two separate E/M services unless one of the services is for a preventive exam as outlined in section C of the policy. In addition, annual wellness visits (G0438 and G0439) will not be eligible for separate reimbursement when reported with preventive medicine E/M (99831-99397).

Our updated editing systems will also focus on guidelines from the AMA and CMS regarding the billing of E/M services by one or more providers. Inpatient E/M services such as inpatient admission, observation services and consultation services should only be billed once by the same provider during an inpatient stay. In addition, in alignment with CMS (or taking guidance from CMS), we will allow one hospital discharge day management service (CPT codes 99238 and 99239) per hospital stay.

Missouri: The Health Plan recognizes that there is duplication of the indirect practice expense when performing both the preventive exam and the problem-oriented E/M during the same encounter. The duplication of indirect practice expense may include, but is not limited to, scheduling the visits, staffing, obtaining vital signs, lighting, and supplying the examination room for both the preventive exam and the problem-oriented E/M. Therefore, when based on the guidelines above, the problem-oriented E/M is eligible for separate reimbursement. The maximum allowance for the reported problem-oriented E/M code will be reduced by 50%.

Once per lifetime
– New claim edit

This edit will, based on correct coding, assess whether services considered once in a lifetime, for example an appendectomy or hysterectomy, have been billed more than once per member. When the system detects that more than one per lifetime service has been performed on a member, the system will deny the subsequent once per lifetime service.

Place of Service
– Updates to current professional reimbursement policy

- The Health Plan considers the provision of contrast materials (high and/or low osmolar contrast material (HOCM/LOCM), radiopharmaceutical materials, injection of dipyridamole per 10 mg (J1245), and radioelements for brachytherapy (Q3001), to be included under the facility's charge as part of the technical portion of diagnostic imaging or treatment services when provided in a facility setting. Therefore, when these materials or elements are reported by a professional provider with a facility setting place of service, the charges will not be eligible for reimbursement.

- The edit will be strengthened to ensure the place of service is appropriately reported based on the service provided. For example, inpatient hospital services should not be billed with an office place of service.

- Annual review of the language that does not affect the outcome of the reimbursement for claims submitted was updated throughout the policy.

Procedure Code, Diagnosis Code, and Modifier Validation
– This is a reminder of current claim edits. These will be strengthened with the implementation of our new editing systems.

- Procedure validation: Editing for procedure code validation uses CPT (AMA) and HCPCS as the reference source. When our claim editing system detects an invalid code for the date of service reported, the claim line will be denied and the provider must resubmit with the correct information.

- Diagnosis code validation: ICD-9-CM or ICD-10-CM validation is based on the World Health Organization (WHO) and CMS when determining additional digit requirements (4th and 5th digit). When our claim editing system detects an invalid diagnosis code for the date of service reported, the claim line will be denied and the provider must resubmit with the correct information.

- Modifier to procedure code validation: Editing for validation is based on CPT, CMS and McKesson sourcing. With enhancements to our systems, when an invalid modifier to procedure code combination is detected, the line item will be denied with a request that the correct code and modifier combination be resubmitted. The Health Plan validates that the following modifiers are appropriately used with procedure codes: 22, 23, 24, 25, 26, 27, 50, 52, 53, 54, 55, 56, 57, 59, 62, 63, 73, 74, 76, 77, 78, 79, 80, 81, 82, 91, AA, AD, AS, E1-E4, F1-F9, FA, KC, LC, LD, LL, LM, LT, MS, NR, NU, P3, P4, P5, QK, QX, QY, QZ, RA, RB, RC, RI, RR, RT, SA, T1-T9, TA, TC, UE, XE, XP, XS, and XU. (See our Modifier Rules reimbursement policy.)

Procedure to Diagnosis Rule
– This is a reminder of current claim edits plus notification of a new edit (Morton's Neuroma). These will be strengthened with the implementation of our new editing systems.

- Injection codes 64450, 64640, or 20550 will not be eligible for reimbursement when reported with a diagnosis of lesion of plantar nerve (Morton's Neuroma).

- Our Prolonged Services reimbursement policy will now include the diagnosis of post-traumatic stress disorder (PTSD) in our list of diagnosis codes that are eligible for reimbursement when reported with CPT prolonged services codes 99354 and 99355.

Sleep Studies and Related Bundled Services & Supplies
– Updates to current professional reimbursement policy

- For unattended and/or home sleep studies, the Health Plan defines an episode of testing as a seven (7) day period beginning with the first day of testing. Therefore, for claims processed on or after September 11, 2015, when our claim editing system identifies that multiple nights of unattended and/or home testing are reported within a seven (7) day period, only one (1) unit of service will be eligible for reimbursement regardless of the number of nights patient data is obtained to complete the testing. This frequency limit applies to those services included in the code/service group for unattended and/or home sleep studies 95800, 95801, 95806, G0398, G0399, and G0400. (See also our Frequency Editing Reimbursement Policy.)

- The procedures and supplies listed in the chart below are considered inclusive to the performance of polysomnography and other sleep studies/tests and Modifier 59 will no longer override the denial for the bundled services and/or supplies.

A4556	A7027	A7031	A7035	A7039	E0470	E0601	94762
A4557	A7028	A7032	A7036	A7044	E0471	94660	98960
A4558	A7029	A7033	A7037	A7045	E0561	94760	
A4604	A7030	A7034	A7038	A7046	E0562	94761	

Revised Other Policies

Annual review of policy language does not affect the outcome of the reimbursement for claims submitted. Examples of some changes include punctuation, grammatical edits, formatting, clarifications as well as insertions of AMA CPT Handbook terminology.

- Anesthesia Services: This policy was updated July 1, 2015 to document that when TEE services are for monitoring purposes (CPT code 93318) or guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s)… (CPT code 93355), the Health Plan follows NCCI edit logic for code pairs with a 'superscript' of zero or a modifier allowance indicator of zero, and will not override an incidental edit when modifier 59 is used.

- Cancer Treatment Planning and Care Coordination: This policy was updated July 1, 2015 and contains minor language changes.

- Claims Editing Overview: This policy will be revised for the implementation of these edits.

- Co-Surgeon/Team Surgeon Services: This policy was updated July 1, 2015 and contains minor language changes.

- "Incident To" Services: This policy was updated July 1, 2015 and contains minor language changes.

- Pharmaceutical Waste: In our policy dated July 1, 2105, we have documented that we recognize there may be times when a single vial dose of an injectable or infusion drug may be greater than the dosage required for a patient, thereby creating a larger percentage of pharmaceutical waste (e.g., drug shortage). In those instances, we will allow a discard.

- Prolonged Services: This policy was updated July 1, 2015 and contains minor language changes.

- Routine Obstetric Services: This policy was updated July 1, 2015 to include the following language: There may be times when a member does not receive global maternity care (global maternity care consists of all three of the components--antepartum, delivery, and postpartum care) from a single provider or provider group due to various circumstances, for example geographic relocation of the patient or a change in medical practice, and only a specific component of the global maternity care is provided. Under such circumstances, CPT coding does provide individual codes which "breakdown" the global services. The following codes are to be utilized to report the components of maternity care when the global maternity care is not provided:

    - Antepartum only care: 99201-99215 (Antepartum care only; 1-3 visits, each date reported), 59425 (Antepartum care only; 4-6 visits reported as 1 unit), 59426 (Antepartum care only; 7 or more visits reported as 1 unit)

    - Delivery only or delivery with postpartum care only:
        - 59409 Vaginal delivery only (with or without episiotomy and/or forceps)
        - 59410 Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
        - 59514 Cesarean delivery only
        - 59415 Cesarean delivery only; including postpartum care
        - 59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
        - 59614 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
        - 59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
        - 59622 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

    - Postpartum care only: 59430 Postpartum care only (separate procedure) delivery only or delivery with postpartum care only:

- "Rule of Eight" Reporting Guidelines for Physical Medicine and Rehabilitation Services: This policy was updated July 1, 2015 and contains minor language changes.

- Standby Service: This policy was updated July 1, 2015 and contains minor language changes.

- Three-Dimensional (3D) Radiology Services: This policy was updated July 1, 2015 to remove language referencing breast tomosynthesis. Please refer to the applicable Medical Policy.

View reimbursement policies online

– Providers and their staff are strongly encouraged to review our reimbursement policies for information on our edits and guidelines.

Anthem's reimbursement policies are available online at MyAnthem; access via the Availity Web Portal.* (Note: To view online reimbursement policies, you must be registered for access to Availity and MyAnthem functionality.)

Non-Registered for Availity: To register for access to Availity, go to www.availity.com/providers/registration-details/.

Non-Registered for MyAnthem: If your organization is not registered for MyAnthem, sign onto www.anthem.com, select provider, select your state from the dropdown box, press the enter key. In the left corner of the Provider Home Page is an option to register. If you do not have a MyAnthem user id and password, your organization's site administrator must register you as a new user and assign required Anthem-specific functionality. Note: Effective June 21, passwords are no longer generated.

Registered for MyAnthem: If you are a registered MyAnthem user, sign onto www.availity.com, select "My Payer Portals," then choose "Anthem Provider Portal" to be navigated into MyAnthem without entering an additional log-in or password. Select the Administrative Support tab, then select the link labeled **Procedures for Professional Reimbursement** or **Procedures for Facility Reimbursement.**

*For more information, see "MyAnthem and the Availity Web Portal: Access both with one log-in" on page 7 of the June 2014 issue of *Network Update* and "Logging into MyAnthem" at www.anthem.com>Providers (enter state)>Answers@Anthem.

Addendum

Professional Reimbursement Policy	Editing Logic	Processed On or After	Date of Service	Comments
After Hours, Emergency, and Miscellaneous E/M Services	CPT code 99050 is not eligible for separate reimbursement when it is reported with a preventive diagnosis and/or a preventive service.		9/11/2015	
Assistant Surgeon Services	When Modifier AS Non-physician providing assistance in surgery [e.g., Physician Assistant (PA), Registered Nurse First Assist (RNFA) or other non-physician provider as required by state licensure] is appended to a procedure code, the following percent will be applied: Indiana and Missouri - 16% Kentucky, Ohio and Wisconsin - 14%		9/11/2015	
Bundled Services and Supplies	Section I: This edit denies codes for which Anthem does not reimburse when billed alone or with any other procedure and applies to codes: 96155, S0250, S1031, S8301, S9208, S9484, S9485, S9990, S9992 and S9999		9/11/2015	
	Section II: * G0438 and G0439 with preventive E/M codes 99381-99397 * A4595 with 97014 and 97032 * A4215 reported with 97810-97814 * A4556 and A4557 reported with A4595 on the same date of service and/or within 30 days * J2001 or when reported as J3490 with office surgery/procedure codes (Applicable to those services not currently denying J2001 when billed with an office surgery/procedure.) *63081-63088 reported with 22551, 22552, 22554, and 22585, and 63090-63091 with 22612, 22614, 22558, 22585, 22633, and 22634 * 82541, 82542, 82543, 82544 reported with 80300 – 80304, 80320 – 80377 with no modifier override.		9/11/2015	
Claim Editing Overview	Injection codes 64450, 64640, or 20550 will not be eligible for reimbursement when reported with a diagnosis of lesion of plantar nerve (Morton's Neuroma).		9/11/2015	
Frequency Editing	Adding a limit of 120 units per 365 days for 95165 [Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)]		9/11/2015	
	Limit A4595 [Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)] to 2 units per 30 days		9/11/2015	

Professional Reimbursement Policy	Editing Logic	Processed On or After	Date of Service	Comments
Frequency Editing (continued)	Limit A6530-A6540 (compression stockings) to 8 per 365 days		9/11/2015	
	Adding various limits for diabetic supplies: A4210 Needle-free injection device, each (2 per 365 days) A4230 Infusion set for external insulin pump, non –needle cannula type (60 per 90 days) A4231 Infusion set for external insulin pump, needle type (60 per 90 days) A4232 Syringe with needle for external insulin pump, sterile, 3CC (60 per 90 days) A4244 Alcohol or peroxide, per pint (12 per 90 days) A4245 Alcohol wipes, per box (24 per 90 days) A4250 Urine test or reagent strips or tablets (100 tablets or strips) (4 per 90 days) A4253 Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips (11 per 90 days) A4257 Replacement lens shield cartridge for use with laser skin piercing device (1 per 30 days) A4258 Spring-powered device for lancet, each (2 per 90 days) A4259 Lancets, per box of 100 (5 per 90 days)		9/11/2015	
	Limit G0249 to 3 units per 90 days" Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism...testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests		9/11/2015	
	Add a limit of 2 per 30 days for A4556 (electrodes) Add a limit of 4 per year for A4557 (lead wires)		9/11/2015	**See also our Bundled Services and Supplies reimbursement policy for additional information.**
	Allow one unit of 96401 (Xolair) with the administration of idiopathic urticaria		9/11/2015	
	Add a limit of once per day for 87530		9/11/2015	
	Add a limit of once per day for 87529		9/11/2015	
	4 per date of service - 90378		9/11/2015	
	Each code is allowed - 1 per 30 days: 93268, 93270, 93271, 93272, 93297, 93298, 93299, 94014, 94015, 94016, 94774, 94775, 94776, 94777, E1812		9/11/2015	

Professional Reimbursement Policy	Editing Logic	Processed On or After	Date of Service	Comments
Frequency Editing (continued)	Each code is allowed - 1 per 90 days of service: 93293, 93294, 93295, 93296		9/11/2015	
	2 per date of service - 93325, J7321, J7323, J7324, J7326		*9/11/2015*	
	1 per 3 days of service - 95250, 95251		9/11/2015	
	120 doses per 365 days - 95165		9/11/2015	
	8 per date of service - 96150, 96151, 96152, 96153, 96154		9/11/2015	
	3 per date of service - 99183		9/11/2015	
	1 per 90 days of service - 99363, 99364		9/11/2015	
	2 per 365 days - A4210, A4258		9/11/2015	
	Each code is allowed - 60 per 90 days: A4210, A4230, A4232		9/11/2015	
	12 per 90 days - A4244		9/11/2015	
	24 per 90 days - A4245		9/11/2015	
	4 per 90 days - A4250		9/11/2015	
	11 per 90 days - A4253		9/11/2015	
	5 per 90 days - A4259		9/11/2015	
	2 per 30 days - A4595		9/11/2015	
	Each code is allowed - 8 per 365 days: A6530, A6531, A6532, A6533, A6544, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6545, A6549		9/11/2015	
	3 per 90 days of service - G0249		9/11/2015	
	95 units per date of service - J9355		9/11/2015	
	44 per date of service - Q4101		9/11/2015	
	1 per date of service - 80321-80322, 80324-80337, 80339-80344, 80346-80347, 83050-80352, 80361, 80362-80364, 80369-80370, 80375-80377		9/11/2015	

Professional Reimbursement Policy	**Editing Logic**	**Processed On or After**	**Date of Service**	**Comments**
Frequency Editing (continued)	16 per date of service - J0696		9/11/2015	
	3 per date of service - J2800		9/11/2015	
	1 per date of service - J7307		9/11/2015	
	1 per 30 days - E0441-E0444	9/11/2015		**Refer to Durable Medical Equipment Policy**
Frequency Editing and Laboratory and Venipuncture	Limit blood collection to 1 per date of service for any code in group 36415 (Collection of venous blood by venipuncture), 36416 (Collection of capillary blood specimen (finger, heel, ear stick)), and S9529 (Routine venipuncture for collection of specimen(s), single homebound, nursing home, or skilled nursing facility patient).		9/11/2015	**To implement any code in group.**
Global Services	Fluid and drug administration services such as therapeutic, prophylactic, and/or local anesthetic injections (e.g., J2001 and 96372)		9/11/2015	
	J2001 and S0020 are considered part of the global surgical package and not eligible for separate reimbursement.	9/11/2015		
Injection and Infusion Administration an d Related Services and Supplies	96367 (in addition to the code for the primary procedure) has a frequency restriction of six times per date of service.		9/11/2015	
Laboratory and Venipuncture Services	Example: If procedure code 80047 (PCTC IND of 9) or 86485 (PCTC IND of 3) is reported with a facility place of service, the line item will deny.		9/11/2015	
	Example: If 78805 is submitted with modifier –TC and without modifier –26 in a facility place of service, the claim line will deny.		9/11/2015	
Modifier Rules	SA (Nurse practitioner rendering service in collaboration with a physician) Surgical services and procedures reported with modifier SA will not be eligible for reimbursement.		9/11/2015	

Professional Reimbursement Policy	Editing Logic	Processed On or After	Date of Service	Comments
Modifier 59 (Distinct Procedural/ Separate/Unusual Service)	A4215 is not eligible for separate reimbursement when reported with 97810-97814 and no modifiers will override		9/11/2015	
	63081-63088 reported with 22551, 22552, 22554, and 22585 and 63090-63091 with 22612, 22614, 22558, 22633, and 22634 (unless limited circumstances are met, such as spinal fracture, spinal infection, or spinal tumor)		9/11/2015	
	63042 and 63047 reported with 22630 or 22633, same interspace		9/11/2015	
	82541, 82542, 82543 and/or 82544 reported with 80300–80304 and 80320–80377		9/11/2015	
	A4215 reported with 97810-97814		9/11/2015	
	A4595 reported with 97014 and 97032		9/11/2015	
Multiple and Bilateral Surgery	Primary and subsequent procedures for standard multiple surgery reimbursement rules will be determined by the current highest relative value unit (RVU) rather than the highest maximum allowance. Reductions will be applied systematically for those services applicable to multiple procedure reductions even when multiple units are billed on one line.		9/11/2015	**Refer to the policy for further detail**
	Multiple arthroscopic and endoscopic surgical procedure reimbursement Arthroscopic and endoscopic surgical reimbursement in the same base family as defined by the Centers for Medicare & Medicaid Services (CMS) is 100% of the maximum allowance for the procedure with the highest RVU for the place of service and date of service, and a lower percentage for each subsequent procedure when performed during the same operative session.		9/11/2015	
	For example: Procedure code A has the highest RVU value and will thus be reimbursed at 100% of the allowed amount. Procedure codes B and C have lower RVU values and will be reimbursed at 25% of the allowed amount			
	Bilateral surgical procedure reimbursement When a bilateral surgery that uses a unilateral code is reported with other surgical procedures, we will increase the RVU for the applicable unilateral code by 150%. We will then apply our multiple surgical rules.		9/11/2015	

Professional Reimbursement Policy	Editing Logic	Processed On or After	Date of Service	Comments
Multiple Diagnostic Radiology	Reimbursement will be 100% of the maximum allowance for the first imaging procedure with the highest Relative Value Unit (RVU) for the date of service, and 50% of the maximum allowance for each subsequent imaging procedure for that date of service that has an MPI of 4. When two or more imaging procedures with an MPI of 4 are reported as global imaging procedures, we will determine the primary imaging procedure based on the global RVUs for the date of service. The primary procedure will be 100% and any other imaging procedures with an MPI of 4 rendered on that date of service that are reported globally, the claim editing systems will identify and calculate per the following: • the technical component RVU will be reduced by 50%. • the professional component RVU will remain at 100%. • these two values are added together to obtain a new RVU value to be used in the calculation. • the new RVU value is then divided by the original total global RVU and multiplied by 100 to determine what percent of the global value is to be applied to such imaging procedures. • the original fee schedule global allowance is then multiplied by this new percentage value (which is rounded up) to determine the [maximum allowance] for such imaging procedure with an MPI of 4.		9/11/2015	**Refer to the policy for further detail.**
Multiple Evaluation and Management Services and Related Modifiers -25 & -57	Modifier 25 will not be accepted when it is reported by the same provider on the same day for two separate E/M services unless one of the services is for a preventive exam as outlined in section C of the policy.		9/11/2015	
	Annual wellness visits (G0438 and G0439) will not be eligible for separate reimbursement when reported with preventive medicine E/M services (99831-99397).		9/11/2015	
Place of Service	When reported by a professional provider in a facility place of service, radiopharmaceutical codes, including but not limited to, A4641-A4642, A9500-A9505, A9507-A9510, A9512, A9516-A9517, A9520-A9521, A9524, A9526-A9532, A9536-A9548, A9550-A9572, A9575-A9586, A9599-A9600, A9604, A9698-A9700, Q9951, Q9953-Q9969, Q3001 and J1245, will not be eligible for reimbursement.		9/11/2015	

Professional Reimbursement Policy	Editing Logic	Processed On or After	Date of Service	Comments
Place of Service (cont.)	Certain complex surgeries can only be performed in an inpatient setting due to the needed level of involvement of qualified staff and the technical equipment necessary to perform the procedure and will not be eligible for reimbursement when reported with a place of service other than the inpatient setting. Examples of CPT and HCPCS code ranges include, but are not limited to, 32440-32491, 32851-32854, 33236-33238, 33400-33403, 33510-33530, 33600-33619,S2053-S2065, S2205-S2209.	9/11/2015		**Refer to policy for further detail on existing language. The claim editing systems will strengthen existing edits.**
Sleep Study Bundled Services Supply	Modifier 59 will no longer override the denial for the bundled services and/or supplies listed below. A4556 A7027 A7031 A7035 A7039 E0470 E0601 94762 A4557 A7028 A7032 A7036 A7044 E0471 94660 98960 A4558 A7029 A7033 A7037 A7045 E0561 94760 A4604 A7030 A7034 A7038 A7046 E0562 94761		9/11/2015	