Claims Submission

Claims Requirements

A claim is the uniform bill form or electronic submission form in the format used by Anthem and submitted for payment by a Provider for covered services rendered to an Anthem member. Anthem only accepts one member and one Provider per claim.

We encourage you to submit claims electronically. Electronic claims submission is fast, accurate and reliable. Electronic claims may be submitted 24 hours a day, seven days a week. If complete information is provided, they will typically be processed seven to 10 days faster than paper claims. Please see the Electronic Claims Submission subsection in this section of the Manual for more information. Also visit our web site at www.anthemp.com/edi then click on Nevada as your state. Here you will find information on EDI transactions.

If submitting claims electronically is not a viable alternative, claims must be submitted on a CMS-1500 claim form for professional and other non-facility services and on an UB-04 CMS-1450 claim form for services provided in a facility. To be considered a clean claim, the following information is MANDATORY, as defined by applicable law, for each claim:

A. The following fields of the CMS-1500 claim form must be completed before a claim can be considered a “clean claim:”

1. Field 1: Type of insurance coverage
2. Field 1a: Insured identification number
3. Field 2: Patient’s name
4. Field 3: Patient’s birth date and sex
5. Field 4: Insured’s name
6. Field 5: Patient’s address
7. Field 6: Patient’s relationship to insured
8. Field 7: Insured's address (if same as patient address; can indicate “same”) 
9. Field 8: Patient’s status (required only if patient is a dependent)
10. Field 9 (a-d): Other insurance information (only if 11d is answered in “yes”) 
11. Field 10 (a-c): Relation of condition to: employment, auto accident or other accident;
12. Field 11: Insured’s policy, group or FECA number
13. Field 11c: Insurance plan or program name
14. Field 11d: Other insurance indicator
15. Field 12: Information release (“signature on file” is acceptable)
16. Field 13: Assignment of benefits (“signature on file” is acceptable)
17. Field 14: Date of onset of illness or condition
18. Field 17: Name of referring physician (if applicable)
19. Field 21: Diagnosis code
20. Field 23: Prior authorization number (if any)
21. Field 24: A, B, D, E, F, G) Details about services provided
(C, H Medicaid only)
22. Field 24 I, J: Non-NPI provider information
23. Field 25: Federal tax ID number
24. Field 28: Total charge
25. Field 31: Signature of provider including degrees or credentials (provider name sufficient)
26. Field 32: Address of facility where services were rendered
27. Field 32a: National Provider Identifier (NPI);
28. Field 32b: Non-NPI (QUAL ID), as applicable
29. Field 33: Provider’s billing information and phone number
30. Field 33a: National Provider Identifier (NPI); and
31. Field 33b: Non-NPI (QUAL ID), as applicable

B. The following fields of the UB-04 CMS-1450 claim form must be completed for a claim to be considered a “clean claim:”

1. Field 1: Servicing provider’s name, address, and telephone number
2. Field 3: Patient’s control or medical record number
3. Field 4: Type of bill code
4. Field 5: Provider's federal tax ID number
5. Field 6: Statement Covers Period From/Through
6. Field 8: Patient's name
7. Field 9: Patient's address
8. Field 10: Patient's birth date
9. Field 11: Patient's sex
10. Field 12: Date of admission
11. Field 13: Hour of admission
12. Field 14: Type of admission/visit
13. Field 15: Admission source code
14. Field 16: Discharge hour (for maternity only)
15. Field 17: Patient discharge status
16. Fields 31-36: Occurrence information (accidents only)
17. Field 38: Responsible party's name and address (if same as patient can indicate “same”)
18. Fields 39-41: Value codes and amounts
19. Field 42: Revenue code
20. Field 43: Revenue descriptions
21. Field 44: HCPCS/Rates/HIPPS Rate Codes
22. Field 45: Service/creation date (for outpatient services only)
23. Field 46: Service units
24. Field 47: Total charges
25. Field 50: Payer(s) information
26. Field 52: Information release
27. Field 53: Assignment of benefits
28. Field 56: National Provider ID (NPI)
29. Field 58: Insured's name
30. Field 59: Relationship of patient to insured
31. Field 60: Insured's unique ID number
32. Field 62: Insurance group number(s) (only if group coverage)
33. Field 63: Prior authorization or treatment authorization number (if any)
34. Fields 65: Employer information (for Workers' compensation claims only)
35. Field 66: ICD Version Indicator
36. Field 67: Principal diagnosis code
37. Field 69: Admitting diagnosis code (inpatient only)
38. Field 74: Principal procedure code and date (when applicable); and
39. Field 76: Attending physician's name and ID (NPI or QUAL ID)

Providers must bill with current CPT-IV or HCPCS codes. Codes that have been deleted from CPT-IV or HCPCS are not recognized. When a miscellaneous procedure code is billed or a code is used for a service not described in CPT-IV or HCPCS, supportive documentation must be submitted with the claim.

Only submit claims after service is rendered. Claims submitted without the above mandatory information are not accepted and will be returned to the Provider. In those cases, please fully complete and return the corrected claim with the Return to Provider Form within 30 calendar days for processing.

Claims denied for incorrect or incomplete information must be resubmitted (with corrected information) on a Claim Action Request Form. Please resubmit the claim with a copy of the Anthem Explanation of Benefits/Remittance Advice showing the claim denial. Return the claim for processing within 30 calendar days of the denial notice. When submitting corrected information on a full, partially paid, or denied claim, an adjustment must be requested on a Claim Action Request Form, rather than submitting a new claim. When an unpaid claim is returned to you with a cover letter stating that additional information is required for processing, please resubmit the corrected claim requested information (as appropriate) with a copy of the cover letter and a completed Claim Action Request Form. Return the corrected claim or requested information for processing within 30 calendar days of the Anthem letter date. Please see the Claim Action Request Procedures section of this Manual for more information.
Submission of Claims under the Federal Employee Health Benefit Program

All Claims under the Federal Employee Health Benefit Program ("FEHBP") must be submitted to Plan for payment within one hundred eighty (180) days from the date the Health Services are rendered. Facility/Professional Provider agrees to provide to Plan, at no cost to Anthem or Covered Individual all information necessary for Plan to determine its liability, including, without limitation, accurate and Complete Claims for Covered Services, utilizing forms consistent with industry standards and approved by Plan or, if available, electronically through a medium approved by Plan. If Plan is the secondary payor, the one hundred eighty (180) day period will not begin to run until Facility/Professional Provider receives notification of primary payor’s responsibility. Plan is not obligated to pay Claims received after this one hundred eighty (180) day period. Except where Covered Individual did not provide Plan identification, Facility/Professional Provider shall not bill, collect or attempt to collect from Covered Individual for Claims Plan receives after the applicable period regardless of whether Plan pays such Claims.

Erroneous or duplicate Claim payments under the Federal Employee Health Benefit Program

For erroneous or duplicate Claim payments under the FEHBP, either party shall refund or adjust, as applicable, all such duplicate or erroneous Claim payments regardless of the cause. Such refund or adjustment may be made within five (5) years from the end of the calendar year in which the erroneous or duplicate Claim was submitted. In lieu of a refund, Plan may offset future Claim payments.

Helpful Tips for Filing Claims

Other Insurance Coverage

When filing claims with other insurance coverage, please ensure the following fields are completed and that a legible copy of the explanation of benefits from the other insurance coverage is attached to the claim:

CMS-1500 Fields:
Field 9: Other insured’s name
Field 9a: Other insured’s policy or group number
Field 9b: Other insured’s date of birth
Field 9c: Employer’s name or school name (not required in EDI)
Field 9d: Insurance plan name or program name (not required in EDI)

UB-04 CMS-1450 Fields:
Field 50a-c: Payer Name
Field 54a-c: Prior payments (if applicable)

Anesthesia Claims

When filing claims for anesthesia services, minutes—rather than units—must be billed. We’ll round the units upward, depending on the minutes billed.

- When multiple surgical procedures are done, only report the anesthesia code with the highest base value with the TOTAL time for all procedures. Multiple anesthesia codes will not be reimbursed. Effective on or after November 7, 2009 with ClaimsXten implementation, if multiple anesthesia codes are billed on the same date of service the line with the lowest charge will be denied.
- Obstetrical epidural anesthesia edits may occur when the reported anesthesia time exceeds 2.5 hours if the provider does not have a global contract. A maximum of 2.5 hours of anesthesia time is routinely allowed. Upon review, additional time units may be allowed with documentation that face-to-face time with the obstetrical patient exceeded 2.5 hours.
- When billing surgery codes, only bill one unit of service as time is not considered. Surgical codes are reimbursed based on the RVU for the surgical procedure times the surgical conversion factor.
- Procedure codes published in CPT Appendix G include moderate sedation (99143 and 99144) as global to performing the procedure and are not eligible for separate reimbursement. See Reimbursement Policy RE.027 Moderate Sedation
- Moderate sedation rendered by a provider who is not performing the diagnostic or therapeutic procedure is not eligible for reimbursement in a non facility setting such as a provider’s office or a clinic.
Modifier AA should be reported in the last modifier position when other payment modifiers such as P3 are billed in order to assure additional allowance is added for the payment modifiers.

If more than one payment modifier is billed, then modifier 99 should be billed in the first position to ensure all payment modifiers are applied. (Example: 99, QX, P3)

Processing guidelines for Pap Smears and PSA tests for members with Individual coverage

We have updated our processing guidelines regarding Pap Smears and PSA exams for members with Individual coverage. While our individual products do not have preventive care benefits, there is a state mandate that allows coverage for PSA, mammogram and pap smears tests. As members need to see their physicians in order to obtain these mandated benefits we are also allowing for the Evaluation and Management code even though the member does not have preventive care benefits in their plan.

For Pap Smears: You should indicate that a pap smear was obtained in addition to the GYN exam (diagnosis code V72.31) by adding routine cervical Pap smear (diagnosis code V76.2) as the secondary diagnosis code. This is for informational purposes, and will help us adjudicate the claim appropriately, as we’ll know to expect the lab portion of the Pap smear claim in addition to the office visit claim.

For PSA Test: You should indicate that a PSA test was drawn during a general medical exam (diagnosis code V70.0) by adding PSA/screening for prostate cancer test (diagnosis code V76.44) as the secondary diagnosis code. This is for informational purposes, and will help us adjudicate the claim appropriately, as we’ll know to expect the PSA test claim in addition to the office visit claim.

If only the preventative visit is billed for these members, rather than indicating the Pap smear or PSA test was done, the claim will be denied because we’ll have no way of knowing that the member had a Pap smear or PSA test completed during that office visit. Claims without this additional coding will be denied as preventive care services for those members that do not have preventive care benefits.

DME Rental Claims

Please do not submit claims until the rental period is completed. When itemizing sales tax as a separate billed charge, please use modifier RR with procedure code S9999.

Medical Records and Situations When Clinical Information Is Required

See the Medical Records and Situations When Clinical Information is Required Submission Guidelines on the last two pages of this section. Please note requirement for records for prolonged attendance.

Modifier 99

You must use modifier 99 in the first position on claim lines with multiple modifiers so all modifiers are considered for claims processing. Modifier 99 will cause a claim to pend so all modifiers can be considered for processing.

Modifiers

For more information, please see the Claims Editing Software Programs portion of this section and the Additional Edits and Modifier Rules section on the secure provider portal, ProviderAccess.

Late Charges

Late charges for claims previously filed can be submitted electronically. You must reference the original claim number in the re-billed electronic claim. If attachments are required, please submit them on paper with the completed Claim Action Request Form.

Credits

For an original billing the total billed amount for each line must equal the total charges for the claim; therefore, don’t itemize credit dollar amounts. If the original services were over-billed, please submit the correction on the Claim Action Request Form.
Zero/Negative Charges
When filing claims for procedures with negative charges, please don’t include these lines on the claim. Negative charges often result in an out-of-balance claim that must be returned to the Provider for additional clarification.

Ambulatory Surgical Centers
When billing revenue codes, always include the CPT and HCPCS code (if applicable) for the surgery being performed. This code is required to determine the procedure, and including it on the claim helps us process the claim correctly and more quickly. Ambulatory surgical claims must be billed on a UB-04 CMS-1450 claims form.

Date of Current Illness, Injury or Pregnancy
For any 800-900 diagnosis code, an injury date is required. For a pregnancy diagnosis, the date of the member’s last menstrual cycle is required to determine a pre-existing condition.

Type of Billing Codes
When billing facility claims, please make sure the type of bill coincides with the revenue code(s) billed on the claim. For example, if billing an outpatient revenue code, the type of bill must be for outpatient services.

Occurrence Dates
When billing facility claims, please make sure the surgery date is within the service from and to dates on the claim. Claims that include a surgical procedure date that falls outside the service from and to dates will be returned to the Provider.

Present on Admission (POA)
This section applies to acute care inpatient hospital claims with bill types of 11X or 12X.

The following hospitals are EXEMPT from the POA indicator requirement:
- Critical Access Hospitals (CAHs)
- Long-Term Care Hospitals (LTCHs)
- Maryland Waiver Hospitals
- Cancer Hospitals
- Children’s Inpatient Facilities
- Inpatient Rehabilitation Facilities (IRFs)
- Psychiatric Hospitals

Paper Claims
On the UB04, the POA indicator is the eighth digit of Field Locator (FL) 67, principal diagnosis, and the eighth digit of each of the secondary diagnosis fields, FL 67 A-Q. Report the applicable POA indicator (Y, N, U, or W) for the principal and any secondary diagnoses and include this as the eighth digit; leave this field blank if the diagnosis is exempt from POA reporting. Claims submitted with an invalid POA indicator will be returned to the submitter.

Y - Diagnosis was present at time of inpatient admission
N - Diagnosis was not present at time of inpatient admission
U - Documentation insufficient to determine if condition was present at the time of inpatient admission
W - Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission
1 - Exempt from POA reporting. This code is the equivalent code of a blank on the UB-04, however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1
National Provider Identifier

The National Provider Identifier (NPI) is one provision of the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Anthem requires the NPI (as your only provider identifier) on Electronic and Paper transactions.

Location of the NPI on claim forms

NPI location for electronic transactions:

- The NPI will be reported in the Provider loops on electronic transactions. The following elements are required:
  - The NM108 qualifier will be “XX” for NPI submission.
  - The NM109 field will display the 10-digit NPI.
  - The TIN will be required in the Ref segment when the NPI is reported in the NM109.
  - The REF01 qualifiers (EI = TIN; SY = Social Security number)
  - The REF02 field will display the Provider’s or facility’s TIN or Social Security number.

- The chart below outlines the changes for 837 professional, institutional and dental claims:

<table>
<thead>
<tr>
<th>Field</th>
<th>Locator</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Identifier Qualifier</td>
<td>NM108 qualifier</td>
<td>Key “XX” for NPI submission.</td>
</tr>
<tr>
<td>Primary Identifier</td>
<td>NM109 field</td>
<td>Key the 10-digit NPI. (The tax ID number will be required in the Ref segment when the NPI is reported in the NM109 locator.) This requirement of Tax ID will be on Billing, Pay to, and rendering Provider loops only.</td>
</tr>
<tr>
<td>Secondary Identifier Qualifier</td>
<td>REF01 qualifiers</td>
<td>Key “EI” (tax identification) or “SY” (Social Security number).</td>
</tr>
<tr>
<td>Secondary Identifier</td>
<td>REF02</td>
<td>Key the Provider tax ID number or Social Security number.</td>
</tr>
<tr>
<td>Other Identifier not considered legacy IDs Optional</td>
<td>REF01</td>
<td>Key “LU” (location number), “0B” (state license number)</td>
</tr>
<tr>
<td>Other Identifier not considered legacy IDs Optional</td>
<td>REF02</td>
<td>Key the location number or state license number</td>
</tr>
</tbody>
</table>

NPI location on the electronic remittance advice (835):

<table>
<thead>
<tr>
<th>Loop/Segment</th>
<th>Inst</th>
<th>Prof</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loop 1000B; N103</td>
<td>XX</td>
<td>XX</td>
</tr>
<tr>
<td>Loop 1000B; N104</td>
<td>NPI</td>
<td>NPI</td>
</tr>
<tr>
<td>Loop 1000B; REF01</td>
<td>TJ</td>
<td>TJ</td>
</tr>
<tr>
<td>Loop 1000B; REF02</td>
<td>TIN</td>
<td>TIN</td>
</tr>
<tr>
<td>Loop 2000; TS301</td>
<td>Not used</td>
<td>Not used</td>
</tr>
<tr>
<td>Loop 2100; NM108</td>
<td>XX</td>
<td>XX</td>
</tr>
<tr>
<td>Loop 2100; NM109</td>
<td>NPI</td>
<td>NPI</td>
</tr>
</tbody>
</table>

NPI location on paper forms:

- Revised CMS-1500 (08/05)
  - The NPI will be displayed in box/field 17b for the referring Provider.
  - The NPI will be displayed in box/field 24j for the rendering Provider.
  - Locators 32a and 33a are also designated for the NPI for the servicing Provider locations and Pay to/billing Provider location.
**NPI Location on Paper Forms (CMS 1500 - 8/05)**

**ALL:** OCTOBER 2009

6.7
NPI location on paper forms:

- UB-04 CMS-1450
  - The NPI will be displayed in the following boxes/fields:
    - Box/field 56 for the facility
    - Box/field 76 for the attending physician
    - Box/field 77 for the operating physician
    - Box/fields 78 and 79 for other provider type (optional)

Timely Filing

**Timely Filing for Claims**

Claims must be submitted within the timely filing timeframe specified in your contract.

All additional information reasonably required by Anthem to verify and confirm the services and charges must be provided on request. The Provider must complete and return requests for additional information within 30 calendar days of Anthem’s request.

Claims submitted after the timely filing period expires will be denied, unless proof of timely filing can be demonstrated according to the guideline listed below.

**Proof of Timely Filing**

Waiver of the timely filing requirement is only permitted when Anthem has received documentation indicating the member or Provider originally submitted the claim within the applicable timely filing period.

The documentation submitted must indicate the claim was originally submitted before the timely filing period expired.
Acceptable documentation includes the following:

1. A copy of the claim with a **computer-printed filing date** (a handwritten date isn’t acceptable)

2. An original fax confirmation specifying the claim in question and including the following information: date of service, amount billed, member name, original date filed with Anthem and description of the service

3. The Provider's billing system printout showing the following information: date of service, amount billed, member name, original date filed with Anthem and description of the service

   If the Provider doesn’t have an electronic billing system, approved documentation is a copy of the member's chart indicating the billed date and/or a copy of the billing records indicating the billed date, and the information listed above.

4. If the claim was originally filed electronically, a copy of Anthem’s electronic Level 2 or your respective clearinghouse’s acceptance/rejection claims report is required; a copy can be obtained from the Provider’s EDI vendor, EDI representative or clearinghouse representative. The Provider also must demonstrate that the claim and the member's name are on the original acceptance/rejection report. Note: When referencing the acceptance/reject report, the claim must show as accepted to qualify for proof of timely filing. Any rejected claims must be corrected and resubmitted within the timely filing period.

5. A copy of the Anthem letter requesting additional claim information showing the date information was requested.

   If the Provider originally received incorrect insurance information, the Provider has 30 calendar days from the date the Provider is advised of the correct insurance information to file the claim with the correct carrier.

Appeals for claims denied for failing to meet timely filing requirements must be submitted to Anthem in **writing**. Anthem doesn’t accept appeals over the phone.

Any exceptions to the proof of timely filing policy require the signature of the person in the director-level position or above in the applicable Anthem department.

Please send all claims data to the applicable address listed in the Telephone/Address Directory section.

**Electronic Data Interchange (EDI)**

EDI enables providers to submit and receive transactions from their computer systems. Providers can choose to connect directly to Anthem Blue Cross and Blue Shield using vendor software or through a clearinghouse. HIPAA compliant transactions available through EDI include eligibility, benefits and claims status inquiries, claims submissions, electronic remittance advice and electronic funds transfer.

EDI submissions are efficient, have fewer errors and omissions than paper, and provide detailed reports so that providers can audit and track claims during the entire submission process. For more information about EDI submission, benefits, and enrollment visit [www.anthem.com/edi](http://www.anthem.com/edi), > Select State

Electronic Data Interchange (EDI) allows providers to submit and receive electronic transactions from their computer systems. EDI is available for most common health care business transactions, such as:

- 837 Health Care Claim
- 835 Health Care Claim Payment/Remittance Advice
- 270/271 Health Care Eligibility Benefit Inquiry and Response
- 276/277 Health Care Claim Status Request and Response
- 278 Health Care Services Review – Request for Review and Response

Anthem is compliant with all Health Insurance Portability and Accountability Act (HIPAA) requirements and is a strong proponent of EDI transactions because they will significantly reduce administrative and operating costs, gain efficiency in processing time and improve data quality. Under HIPAA, as EDI transactions gradually replace paper-based transactions, the risk of losing documents, encountering delays, and paper chasing is minimized.
The EDI section of this manual includes the information needed to begin and increase the transactions your office is submitting electronically. Visit our online resources to learn more about the services and electronic filing options mentioned in this guide.

Online EDI Resources and Contact Information

We’ve dedicated a website to share electronic information with you and/or your electronic data interchange (EDI) vendors (clearinghouses, software vendors and billing agencies). Our website gives you pertinent and timely information, along with helpful tools to ease electronic transactions. Visit www.anthem.com/edi, select state >click on the Register, Documents, Services or Communications tabs to access all EDI manuals, forms and communications.

Find detailed answers in the Anthem HIPAA Companion Guide

The HIPAA Companion Guide has the details on how to submit, receive and troubleshoot electronic transactions required by HIPAA. Whether you submit directly to us or use a clearinghouse, software vendor or billing agency, the HIPAA Companion Guide and the HIPAA Implementation Guide are effective tools to help address your questions. To view the Companion Guide visit www.anthem.com/edi select state > click on Documents. The more you understand how we process electronic transactions, the better your experience with electronic transactions will be — even if you use an outside service.

What you'll find online:

- EDI registration information and forms
- EDI contacts and support information
- EDI communications and electronic submission tips
- Information on electronic filing benefits and cost-savings
- Online tools for submitting electronic CMS-1500 claims directly to us — at no charge to providers
- Filing instructions for EDI submission of eligibility, benefit and claim status inquiries
- Anthem HIPAA Companion Guide with complete information on submitting and receiving electronic transactions
- Anthem report descriptions
- List of clearinghouses, software vendors and billing agencies
- FAQs and answers about electronic transactions
- Information and links pertaining to HIPAA
- Contractual agreements with our trading partners

You will find answers to the most frequently asked questions about submission options, connectivity, troubleshooting tips, contact information and much more.

Contact the EDI Solutions Helpdesk

For more information about electronic claims filing, electronic remittance advice, eligibility benefit inquiry, claim status and other transactions, call the Anthem EDI Solutions Helpdesk for details. Our Helpdesk can address questions regarding connectivity, registration, testing and the implementation process.

Business hours: 8:00 a.m. – 5:00 p.m. Mountain Standard Time
Phone: 800-332-7575
Fax: 303-764-7057
E-mail: edianthemwest.support@anthem.com
Website/Live Chat: www.anthem.com/edi > Select state >click the button at the top of the screen for Live Help

Live Chat is an instant messaging service where the EDI Solutions Helpdesk specialists are available to answer questions from our customers.

Submitting and Receiving EDI Transactions

Visit our web site at www.anthem.com/edi >Select state for enrollment and a listing of vendors and clearinghouses, or refer to our HIPAA Anthem Companion Guide for complete instructions on how to send and receive transactions electronically.
Select EDI Submission Approach

837 Health Care Claim
Providers must manage their own unique set of marketplace requirements, operational needs, and system capabilities. Two basic methods are available to generate EDI transactions:
- Direct submission by provider
- Submission by clearinghouse or billing service

Direct Submission by Provider
Under the direct submission approach, the trading partner is the provider. The provider’s internal programming staff or systems vendor modifies the computer system to meet the format and quality requirements of the ASCX12N HIPAA Implementation Guides and Anthem Companion Guide. The responsibility of operating the computer, modem, communications software, and data compression software also lies with the staff or vendor.

Submission by Clearinghouse or Billing Service
Under the submission by a Clearinghouse or Billing Service approach, the clearinghouse or Billing Service is the Trading Partner. Services are paid by the Provider for the EDI preparation, submission, and/or practice management. The business relationship between the Trading Partner and Provider is held strictly between the two parties. Typically, the Clearinghouse will help you configure the necessary computer equipment or billing software.

Troubleshooting Electronic Submissions

Who do I contact if unable to get connected?
- Direct submitters: contact our EDI Solutions Helpdesk.
- Clearinghouse or vendor: contact your designated customer service support center.

How do I know when to contact Anthem or my clearinghouse and/or vendor?
- Direct submitters: For technical difficulties, problems with reports or any other related issues pertaining to electronic transactions contact your designated customer support center, or if directed to contact Anthem, contact our EDI Solutions Helpdesk.
- Clearinghouse or vendor: For technical difficulties with electronic transactions, contact your designated customer service support center.

Who to contact to reset my password?
- Direct submitters: contact our EDI Solutions Helpdesk.
- Clearinghouse or vendor: contact your designated customer service support center.

EDI Reports Speed Account Reconciliation
Electronic transactions produce an immediate acknowledgement report from Anthem, a virtual receipt of your claims. You will also receive a response report listing claim detail and initial entry rejections, which can immediately be corrected and resubmitted.

Timely reporting lets you quickly correct errors so you can re-submit electronic transactions quickly — speeding account reconciliation. The two-stage process, outlined below, must be closely monitored. Please implement ways to monitor submissions and reconcile errors with electronic transactions during these stages. If you work with an EDI vendor, clearinghouse or billing agency, it’s your responsibility to ensure reports are accurate, flexible, clear and easy to understand. Additionally, please ensure your office staff receives appropriate training on report functions.

You can find Anthem report descriptions, along with formatting specifications, error listings and troubleshooting tips online at www.anthem.com/edi >select state >Documents>and refer to our HIPAA Anthem Companion Guide

Stage 1: EDI Reconciliation — Provider’s Office/Facility to EDI Vendor
Stage 2: EDI Reconciliation — EDI Vendor to Payer
Report Basics

- Work reports each day, ensuring prompt handling of claims
- Reconcile both claim totals and dollars
- Correct claims with errors and resubmit them electronically to provide an audit trail and to avoid payment delays
- Work with EDI vendors to ensure Anthem reports are available. Our reports are your receipt that claims were either accepted for processing or rejected due to errors.
- If you use an EDI vendor, you should work with them directly if there are questions about data content, delivery times, formatting or errors

Electronic Remittance Advice (ERA)

835 Health Care Claim Payment/Remittance Advice
We offer secure electronic delivery of remittance advices, which explain claims in their final status. This is an added benefit to our electronic claim submitters. If you are an electronic claims submitter and currently receive paper remits, contact the EDI Solutions Helpdesk today to enroll for electronic remits.

Facilities can reduce accounts receivable days and administrative expenses by taking advantage of automated posting options often available with an electronic remittance. The content on the Anthem remittance advice meets HIPAA requirements, containing nationally recognized HIPAA compliant remark codes used by Medicare and other payers.

How to enroll for ERA
Download the ERA enrollment form from our web site or refer to the HIPAA Companion Guide for additional details. Go to www.anthem.com/edi > select state > click Register > EDI Registration Form

Using a vendor or a clearinghouse
If you use an EDI vendor and/or submit to a clearinghouse, please contact their representatives to discuss the electronic remittances. This will ensure that ERA enrollment procedures are followed appropriately with the vendor and with Anthem.

Changes after enrollment
It is very important that you notify us of any changes to your ERA request form both before and after enrollment. This includes any changes to your vendor, TIN#, or billing address. Complete the ERA Request form found on our website.

<table>
<thead>
<tr>
<th>ERA</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment or vendor changes, File Delivery and Formatting</td>
<td>EDI Vendor EDI Solutions Helpdesk 800-332-7575 <a href="http://www.anthem.com/edi">www.anthem.com/edi</a> &gt; select state</td>
</tr>
<tr>
<td>ERA-Claim adjudication, payment and remark codes</td>
<td>EDI Solutions Helpdesk 800-332-7575</td>
</tr>
</tbody>
</table>

Real Time Electronic Transactions

270/271 Health Care Eligibility Benefit Inquiry and Response
276/277 Health Care Claim Status Request and Response
Many health care organizations, including health care partners, payers, clearinghouses, software vendors and fiscal intermediaries offer electronic solutions as a fast, inexpensive and secure method of automating business processes. Anthem has electronic solutions, giving provider’s access to patient insurance information before or at the time of service, using the system of their choice.
- Allows providers to perform online transactions
- Provides coverage verification before services are provided
- Includes detailed information for ALL members, including BlueCard.

Features

Eligibility benefit inquiry/response is a real time transaction that provides information on patient eligibility, coverage verification, and patient liability (deductible, co-payment, coinsurance)
Claim status request and response is also a real time transaction that indicates whether an electronic claim has been paid, denied or in progress.

Getting Connected With EDI Batch or Real time Inquires

- Clearinghouses and EDI vendors often have easy-to-use web and automated solutions to verify information for multiple payers simultaneously through one portal in a consistent format.
- Contact your EDI software vendor or clearinghouse to learn more about options available.
- For connectivity options and file specification our HIPAA Companion Guide is available at www.anthem.com/edi >select state

Medicare Crossover Claims:

Ensure crossover claims are forwarded appropriately, remember to always include:

- Complete health insurance claim number (HICN)
- Patient’s complete member identification number, including the three character alpha prefix
- Member name as it appears on the patient’s identification card, for supplemental insurance

Reduce Duplicate Billing:

- Do not file with us and Medicare simultaneously.
- Wait until you receive the Explanation of Medicare Benefits (EOMB) or payment advice from Medicare.
- Payment from supplemental insurers should, as a rule, occur only after the Medicare payment has been issued. CMS requests that you do not bill your patients’ supplemental insurers for a minimum of 15 work days after receiving the Medicare payment.

After you receive the EOMB, determine if the claim was automatically crossed over to the supplemental insurer. If the claim was crossed over, the payment advice/EOMB should typically have “Remark Code MA 18” printed on it, which states, “The claim information is also being forwarded to the patient’s supplemental insurer. Send any questions regarding supplemental benefits to them.” The code and message may differ if the contractor does not use the ANSI X12 835 payment advice. If the claim was crossed over, do not file for the Medicare supplemental benefits.
Explanation of Benefits (EOB) and Remittance Advice (RA)

The explanation of benefits (EOB) or Remittance Advice (RA) will include the information needed to post claims for each member included during this processing cycle. Anthem will send one check to cover the total amount on the EOB/RA. To receive your EOBs/RAs electronically, please call 800-332-7575, or download the 835 registration form at www.anthem.com/edi.

EOBs and RAs are in the same format for all local and BlueCard® members. See the sample EOB and RA below.
**Explanation of Benefits Data Dictionary**
The following list provides definitions for all data fields in the explanation of benefits, which we send to Providers who submit claims on a CMS-1500 Form.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account Number</td>
<td>The account number your office has assigned to our member’s account. This number will be repeated on each claim/EOB.</td>
</tr>
<tr>
<td>Adjustment Information</td>
<td>This line follows the claim detail and indicates if the claim is an adjustment. If it’s an adjustment, the original claim’s EOB sequence number is cross-referenced.</td>
</tr>
<tr>
<td>Adjustments Payable (to the) Provider</td>
<td>A supplemental adjustment that will increase the Anthem paid amount for a claim and will be added to the current EOB</td>
</tr>
<tr>
<td>Allowed Amount</td>
<td>The schedule of maximum allowable amounts</td>
</tr>
<tr>
<td>Billed Amount</td>
<td>The amount the Provider billed Anthem for the service</td>
</tr>
<tr>
<td>Claim ID</td>
<td>The document control number (DCN), which is the number Anthem assigns for each claim, document and letter which is received by Anthem. The first five numbers are the Julian date.</td>
</tr>
<tr>
<td>Claims Payment</td>
<td>The allowed amount minus the deductible amount minus the coinsurance/copayment amount, i.e., the allowed amount minus the member’s financial responsibility</td>
</tr>
<tr>
<td>Claims Payment/Adjustments</td>
<td>A summary of all the claims and adjustments from the previous pages of the EOB found in the Payment Summary box on the last page of the EOB</td>
</tr>
<tr>
<td>Claim Received Date</td>
<td>The date Anthem received the original claim – (which is the same as the DCN date)</td>
</tr>
<tr>
<td>Coinsurance/Copayment Amount</td>
<td>The amounts, which are determined by the member's certificate, that the member must pay</td>
</tr>
<tr>
<td>Deductible Amount</td>
<td>The amount, which is determined by the member's certificate, that the member must pay before benefit payments begin</td>
</tr>
<tr>
<td>Deferred Adjustments Due</td>
<td>Adjustment(s) indicated on the current EOB. The indicated amount(s) will be withheld from an EOB 30 days from the current EOB date – not from this EOB. (Note: this amount is not taken from this remittance advice, but will be taken from a future remittance as a “Deferred Claims Adjustment Withhold” if the overpayment is not received within the 30 day time period.)</td>
</tr>
<tr>
<td>Deferred Claims Adjustment Withhold</td>
<td>A list of any overpayment(s) being deducted from the current payment. Each claim is itemized and includes the member’s name, account number, service dates, sequence number, reason code, withhold amount and the telephone number to call for inquiries. (Note: a sequence number will be displayed referring to the original remittance advice where the notification occurred title “Deferred Adjustment Due”).</td>
</tr>
<tr>
<td>ID Number</td>
<td>The member’s unique Anthem identification number, which has an alpha character in the fourth position (Note: all local member’s ID numbers include a 3 character alpha prefix which is part of their member ID number. For local member’s only, alpha prefix is not included on the EOB)</td>
</tr>
</tbody>
</table>
### OUTPATIENT

<table>
<thead>
<tr>
<th>PATIENT ACCT NUMBER</th>
<th>PATIENT NAME</th>
<th>CONTRACT TYPE</th>
<th>SERVICE DATES FROM TO</th>
<th>APPROVED DAYS</th>
<th>TOTAL CHARGES</th>
<th>COVERED CHARGES</th>
<th>PROVIDER LIABILITY</th>
<th>CLAIMS PAID AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>784714-0001</td>
<td>DOE, J.</td>
<td>PREX</td>
<td>052606</td>
<td>052606</td>
<td>000...</td>
<td>602.50</td>
<td>409.64</td>
<td>119.16</td>
</tr>
<tr>
<td>734222-0001</td>
<td>JONES, J.</td>
<td>PBOP</td>
<td>052506</td>
<td>052506</td>
<td>000...</td>
<td>127.06</td>
<td>12.70</td>
<td>114.36</td>
</tr>
<tr>
<td>720502-0001</td>
<td>WILSON, W</td>
<td>IPSE</td>
<td>042006</td>
<td>042006</td>
<td>000...</td>
<td>303.40-</td>
<td>21.40-</td>
<td>352.00-</td>
</tr>
</tbody>
</table>

### EXPLANATION OF CODES

**CONTRACT TYPES:**
- COE: Premier $25
- COE: $35 Genrix
- COSL: BP Opt 1 15/40/60/30%
- COED: $40 Copay
- COEA: Premier $15
- COEG: HSA 2000

**NETWORK:** NW01 ANTHEM

**ACTION CODES:**

THIS IS NOT A BILL

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. * Registered Marks Blue Cross and Blue Shield Association.
Remittance Advice Data Dictionary
The following list provides definitions for all data fields in the remittance advice, which we send to Providers who submit claims on a UB-04 CMS-1450 Form.

<table>
<thead>
<tr>
<th>Field</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Code</td>
<td>A three-digit code indicating the final outcome of the claim. If the claim is paid, “PAID” will display. A list of applicable codes is provided in the remittance advice explanation of codes section.</td>
</tr>
<tr>
<td>Approved Days</td>
<td>Inpatient days approved by utilization review. For outpatient days, approved days will be displayed as “000.”</td>
</tr>
<tr>
<td>Check Amount</td>
<td>The total amount paid for the claims listed in the remittance advice.</td>
</tr>
<tr>
<td>Claim Number</td>
<td>The unique document control number (DCN), which is the number Anthem assigns for each claim received. The first five numbers are the Julian date.</td>
</tr>
<tr>
<td>Claims Paid Amount</td>
<td>The total amount to be paid to the Provider for each claim listed on the remittance advice.</td>
</tr>
<tr>
<td>Claims Payments/Adjustments</td>
<td>A summary of payments and adjustments for all inpatient and outpatient claims detailed in the remittance advice.</td>
</tr>
<tr>
<td>Contract Type</td>
<td>The type of Anthem coverage the member has. A list of contract types for claims in the specific remittance advice is displayed in the explanation of codes section.</td>
</tr>
<tr>
<td>Covered Charges</td>
<td>The maximum allowed amounts for the services covered by the member’s certificate.</td>
</tr>
<tr>
<td>Deferred Claims Adjustment Withhold</td>
<td>Any overpayment adjustment withholds that have not been repaid to Anthem within the 30-day timeframe. Each claim is itemized and includes information about the overpayment adjustment withheld. The remittance advice check will be reduced by the amount(s) identified in this section. (Note: a sequence number will be displayed referring to the original remittance advice where the notification occurred title “Deferred Inpatient/Outpatient Adjustment Due”).</td>
</tr>
<tr>
<td>Deferred Inpatient Adjustments Due</td>
<td>The amount of overpayment adjustment for an inpatient claim identified on the remittance advice. This amount is deferred for 30 days and notification letters are sent to the Provider. (Note: this amount is not taken from this remittance advice, but will be taken from a future remittance as a “Deferred Claims Adjustment Withhold” if the overpayment is not received within the 30 day time period.)</td>
</tr>
<tr>
<td>Deferred Outpatient Adjustments Due</td>
<td>The amount of overpayment adjustment for an outpatient claim identified on the remittance advice. This amount is deferred for 45 days and notification letters are sent to the Provider. (Note: this amount is not taken from this remittance advice, but will be taken from a future remittance as a “Deferred Claims Adjustment Withhold” if the overpayment is not received within the 30 day time period.)</td>
</tr>
<tr>
<td>Explanation of Codes</td>
<td>Definitions for the contract types, networks utilized and action codes listed in the claim detail line information of the remittance advice and displayed on the second-to-last page of the remittance advice.</td>
</tr>
<tr>
<td>Payment Summary</td>
<td>The last page of the remittance advice, which displays the summary breakdown of payments, adjustments, overpayment adjustment withholds and interest payments.</td>
</tr>
<tr>
<td>Inpatient Adjustments Payable Provider</td>
<td>The total amount of all inpatient claims adjustments identified on the remittance advice that are to be credited to the Provider.</td>
</tr>
<tr>
<td>Issue Date</td>
<td>The date the remittance advice was generated.</td>
</tr>
<tr>
<td>Member ID number</td>
<td>The member’s unique Anthem identification (ID) number. The unique ID is a series of nine characters with a letter in the fourth position. (Note: all local member’s ID numbers include a 3 character alpha prefix which is part of their member ID number. For local member’s only, alpha prefix is not included on the EOB)</td>
</tr>
</tbody>
</table>
| Member Liability                           | The amount, which is determined by the member’s certificate, that the member must pay before benefit payments begin including copayments/coinsurance, deductible, and non-

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<table>
<thead>
<tr>
<th>Network</th>
<th>The grouping of health care Providers Anthem contracts with to provide health care services to our members.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Claim NBR</td>
<td>Not currently used in the remittance advice.</td>
</tr>
<tr>
<td>Outpatient Adjustments Payable Provider</td>
<td>The total amount of all outpatient claim adjustments identified on the remittance advice that are to be credited to the Provider.</td>
</tr>
</tbody>
</table>
| Paid Amount | The total amounts to be paid for each of the following categories:  
• Total inpatient claims  
• Inpatient adjustments payable to the Provider  
• Total outpatient claims  
• Outpatient adjustments payable to the Provider  
This column does not include the deferred inpatient or outpatient adjustments due amounts, because the overpayment adjustment is deferred for 30 days. |
| Paid Days | The total number of days for which the claim was paid, which is usually equal to or less than the approved days for inpatient claims. For outpatient claims, “1” will usually be indicated, unless the total “occurrences” for the particular procedure is indicated. |
| Patient Account Number | A patient identifier issued by the Provider for its in-house records and captured only if submitted by the Provider. |
| Patient Name | The last name and first initial of the patient for whom the claim was submitted. |
| Processed | The total amounts identified in the remittance advice for each of the following categories:  
• Total inpatient claims  
• Inpatient adjustments payable to the Provider  
• Deferred inpatient adjustments due  
• Total outpatient claims  
• Outpatient adjustments payable to the Provider  
• Deferred outpatient adjustments due  
A total isn’t indicated for this column because it only identifies the activity of the remittance advice. |
| Provider Liability | The amount of write-off, based on the Provider’s contractual agreement with Anthem. |
| Refer to Seq. No. ___ | An identifier in the body of the remittance advice that a claim adjustment occurred and which is a reference number to the previous remittance advice where the original claim was processed. |
| Reimbursement Rate | The percentage(s), per diem amount or a flat-dollar amount at which the claim is reimbursed for the service or procedure. |
| Remittance Advice | A reimbursement report with detailed line information and a payment summary and issued electronically or on paper from Anthem’s claims processing system. |
| Rsn Cde | A three-digit reason code indicating the outcome of the claim and which is the same as the action code but identified as a reason code for deferred claims adjustment withhold. The reason code definition is displayed below the withhold information. |
| Sequence Number | A series of numbers assigned to each remittance advice that include the Medicare number or TID number, the current year, and a sequential number following the year (e.g., sequence number 2004000004 indicates it’s the fourth remittance advice generated for the Provider in the year 2004). The sequence number restarts at the beginning of each year. |
| Service Dates | The to/from dates indicated for an overpayment adjustment withhold in the financial summary. |
| Service Dates From/To | The dates of service for the claim. |
| Service Type | Indicates whether the claim is for inpatient or outpatient services in the deferred claims adjustment withhold section of the financial summary. |
| Statutory Interest on Delayed Payment | An interest payment from the processing date for a claim not paid within the required timeframe. |
### Subtotal
The total amount Anthem is paying for the claims listed in the remittance advice.

### Total Charges
The amount the Provider bills for the service or procedure.

### Total Inpatient Claims
The initial inpatient claims total listed in the remittance advice and which does not include any adjustment amounts identified in the remittance advice.

### Total Outpatient Claims
The initial outpatient claims total listed in the remittance advice and which does not include any adjustment amounts identified in the remittance advice.

### Withhold Amount
The amount of the overpayment adjustment withhold that will be deducted from the remittance advice check total.

## Claims Editing Software Programs

Services must be reported in accordance with the reporting guidelines and instructions contained in the American Medical Association (AMA) CPT Manual, “CPT® Assistant,” and HCPCS publications. Providers are responsible for accurately reporting the medical, surgical, diagnostic, and therapeutic services rendered to a member with the correct CPT and/or HCPCS codes, and for appending the applicable modifiers, when appropriate.

Anthem uses ClaimCheck® editing software on our claims processing systems. Effective with claims processed on or after November 7, 2009, we will be utilizing another claims editing software product from McKesson, Inc., called ClaimsXten. ClaimsXten incorporates ClaimCheck®, and will include the same incidental, mutually exclusive and unbundled/rebundle edits as well as other editing rules. It also provides the editing tools to incorporate the administration of many of our reimbursement policies.

ClaimsXten will be updated on a quarterly basis. In addition to adding new CPT codes, HCPCS codes, and NCCI edits, McKesson continues to add and revise content based on ongoing review of the entire knowledge base. This continuous process helps to ensure that the clinical content used in ClaimsXten is clinically appropriate and withstands the scrutiny of both payers and providers. The quarterly updates will be incorporated without specific notification.

ClaimCheck® and ClaimsXten are used to evaluate the accuracy of medical claims and their adherence to accepted CPT/HCPCS coding practices. American Medical Association Complete Procedural Terminology (CPT®), CPT Assistant, coding guidelines developed from national specialty societies, The Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI), Healthcare Common Procedure Coding System (HCPCS®), American Society of Anesthesiology (ASA), and other standard-setting organizations for claims billing procedures are considered in developing Anthem’s coding and reimbursement edits and policies.

Anthem has made customizations to this software to support our Reimbursement Policies. (The list of reimbursement policies is posted in our provider portal, ProviderAccess. If you are not currently registered, see the Customer Service and ProviderAccess section for further details).

These claims editing systems allow us to monitor the increasingly complex developments in medical technology and procedure coding used to process physician payments. ClaimCheck and/or ClaimsXten perform the following types of edits:

- **Procedure unbundling** occurs when two or more procedures are used to describe a service when a single, more comprehensive procedure exists that more accurately describes the complete service performed by a Provider. In this instance, the two codes may be replaced with the more appropriate code by our bundling system.
- An **incidental procedure** is performed at the same time as a more complex primary procedure. The incidental procedure doesn't require significant additional physician resources and/or is clinically integral to the performance of the primary procedure.
- **Mutually exclusive procedures** are two or more procedures usually not performed during the same patient encounter on the same date of service. Mutually exclusive rules may also govern different procedure code descriptions for the same type of procedure for which the physician should be submitting only one procedure.
- **National Correct Coding Initiative (NCCI or CCI) edits** developed by CMS will be applied effective on or after November 7, 2009 with the implementation of ClaimsXten. These edits will be applied to code pairs after the standard ClaimsXten incidental, mutually exclusive and/or re-bundled edits have been applied and will follow the NCCI modifier allowed designations.
- **Duplicate procedure** editing involves duplicate procedures submitted with the same date of service. Duplicate procedures include the following:
  - When the description of the procedure contains the word “bilateral,” the procedure may be performed only once on a single date of service.
When the description of a procedure code contains the phrase “unilateral/bilateral,” the procedure may be performed only once on a single date of service.

When the description of the procedure specifies “unilateral” and there is another procedure whose description specifies “bilateral” performance of the same procedure, the unilateral procedure may not be submitted more than once on a single date of service.

When the description of one procedure specifies a “single” procedure and the description of a second procedure specifies “multiple” procedures, the single procedure may not be submitted more than once on a single date of service.

- **The global duplicate value** is the total number of times it’s clinically possible or medically necessary to perform a given procedure on a single date of service across all anatomic sites.

- **Site-specific auditing logic** uses modifiers to determine if the procedure being audited was performed on a different body site. When a modifier indicates that a procedure was performed on a different site, site-specific auditing logic will then determine whether this difference in sites warrants an override of the edit, with potential separate reimbursement recommended for both procedures.

The following site-specific modifiers are used:

RT  RIGHT SIDE
LT  LEFT SIDE
E1  UPPER LEFT, EYELID
E2  LOWER LEFT, EYELID
E3  UPPER RIGHT, EYELID
E4  LOWER RIGHT, EYELID
FA  LEFT HAND, THUMB
F1  LEFT HAND, SECOND DIGIT
F2  LEFT HAND, THIRD DIGIT
F3  LEFT HAND, FOURTH DIGIT
F4  LEFT HAND, FIFTH DIGIT
F5  RIGHT HAND, THUMB
F6  RIGHT HAND, SECOND DIGIT
F7  RIGHT HAND, THIRD DIGIT
F8  RIGHT HAND, FOURTH DIGIT
F9  RIGHT HAND, FIFTH DIGIT
RC  RIGHT CORONARY ARTERY
LC  LEFT CIRCUMFLEX CORONARY ARTERY
LD  LEFT ANTERIOR DESCENDING CORONARY ARTERY
TA  LEFT FOOT, GREAT TOE
T1  LEFT FOOT, SECOND DIGIT
T2  LEFT FOOT, THIRD DIGIT
T3  LEFT FOOT, FOURTH DIGIT
T4  LEFT FOOT, FIFTH DIGIT
T5  RIGHT FOOT, GREAT TOE
T6  RIGHT FOOT, SECOND DIGIT
T7  RIGHT FOOT, THIRD DIGIT
T8  RIGHT FOOT, FOURTH DIGIT
T9  RIGHT FOOT, FIFTH DIGIT

In certain circumstances, it is appropriate to use modifiers to report services that warrant reimbursement separately from what would usually be expected. The use of these modifiers, listed below should not be routine but instead reserved for special circumstances prompted by an individual situation involving a patient. More information about using modifier 25 and 59 and exceptions to recognition of modifiers 25 and 59 processing guidelines is available on our secure provider portal, ProviderAccess Please go to [www.anthem.com](http://www.anthem.com). Select Provider, Colorado and enter. Log into ProviderAccess through Anthem Online Provider Services blue box on the left side of the page. From the Overview tab, under the Policies and Procedures section, select the link titled “Modifier 25 & 59 Rules”.

- **Modifier 25** is used to indicate that on the day a procedure or preventive exam was performed, the patient’s condition required a significant, separately identifiable evaluation and management (E&M) service beyond the usual care associated with the procedure or preventive exam. Without the modifier-25 designation, the E&M code is bundled into the procedure, or preventive exam. Only append modifier 25 to evaluation and management codes 99201-99499.

  - Routine use of modifier 25 to avoid bundling edits is inappropriate.
Only use modifier 25 for unique situations as indicated above.
If modifier 25 is appended to inappropriate codes, it will be disregarded. Or denied as inappropriate use of the modifier.
To expedite processing of adjustments to add modifier 25 when it wasn’t originally billed, supporting documentation is required. Documentation isn’t required when using modifier 25 on the initial claim.
For more information on Modifier 25 please refer to Anthem’s reimbursement policy RE.022.Modifier 25.

- Modifier 57 is used to identify the patient encounter that resulted in the decision to perform surgery. Without the modifier, the E&M code is bundled to the surgical procedure when performed the day of or the day before a major surgical procedure.
- Modifier 59 is used to identify procedures/services that aren’t normally reported together but are appropriate under the circumstances. This may include a different procedure or surgery, a different site, or a separate incision/excision, lesion or patient encounter. Without the modifier 59 designation, bundling may occur. Effective on or after November 7, 2009 with ClaimsXten implementation of NCCI edits, we will follow most "modifier allowed" CMS logic as well. If the “Modifier Allowed” designation for the code pair is zero; modifiers (such as modifier 59) will not override the edit (Anthem has made customizations to some code pairs and will not allow modifier 59 to override these customizations.)
- Only append modifier 59 to procedures or surgeries.
- Modifier 59 is not appropriate for supplies, other DME codes, or E&M codes.
- If modifier 59 is appended to inappropriate codes, it will be disregarded or denied as inappropriate use of the modifier.
- Routine use of modifier 59 to avoid bundling edits is inappropriate. Only use it in unique situations as indicated above.
For more information on Modifier 59 please refer to Anthems reimbursement policy RE.017.Modifier 59.

- Multiple modifiers: Modifier 99 is used to identify multiply modifiers. Multiple modifiers are sometimes needed to describe a particular code. On a claim line with multiple modifiers that could affect pricing, append modifier 99 in the first modifier position. Our systems only adjudicate the first modifier on the claim line. Appending modifier 99 in the first modifier position will cause the claim to pend so that it can be manually adjudicated with all modifiers reported.
- Modifier 50 is used to indicate a bilateral procedure. Effective November 1, 2007, we will be following CMS guidelines when processing bilateral surgeries/procedures. When a procedure is not identified by its terminology as a bilateral procedure it is billed on one line with the surgical procedure code, one unit of service and modifier 50. Bilateral surgeries/procedures are considered one surgery. The allowable amount is calculated by multiplying 150% of the unit value times the conversion factor. If the code is reported as a bilateral procedure, and is reported with other procedure codes on the same day, then the bilateral adjustment will be applied before applying any multiple procedure rules. This update of bilateral surgeries/procedures billed with (modifier 50) may impact how the multiple surgery reduction is calculated. And, the relative value unit (RVU) on the bilateral procedure may increase now that it will be reimbursed as one procedure causing it to become the primary procedure. For more information about Modifier 50 processing please refer to Anthem Colorado and Nevada Reimbursement Policy RE. 013 Multiple and Bilateral surgery. The notification letter explaining the processing of Modifier 50 is also located on the provider website.

- Age edits occur when the Provider assigns an age-specific procedure or diagnosis code to a patient whose age is outside the designated age range.
- Gender edits occur when the Provider assigns a gender-specific procedure or diagnosis code to a patient of the opposite sex.
- Frequency edits occur when a procedure is billed more often than would be expected. Frequency edits occur when:
  - Base procedure codes are billed with a quantity greater than one on a single date of service.
  - Procedures whose description includes a numeric definition or the term “single,” “one or more”, bilateral or “multiple” are billed with a quantity greater than one on a single date of service.
  - In the case of procedures that are allowed with more than one unit per date of service (DOS), the line item that exceeds the maximum allowed per DOS will be denied and replaced with a new corrected line item showing the appropriate number of units.
  - For more information on frequency edits refer to the Reimbursement Policy: RE.014 Frequency Editing

- PAP Smear lab codes with E&M codes are not eligible for separate reimbursement. In most cases when a family physician, internist or obstetrician/gynecologist submits a cytology/pap smear code they are not the physicians preparing and/or interpreting the pap smear as they are the physicians who obtained the specimen. The pathologist preparing and interpreting the cytology/pap smear must bill for this service separately.
  - Therefore, Anthem Bundles 88141-88155, 88164-88167, 88174-88175 Pap Smear (Papanicolaou test or cytology smear) as mutually exclusive with E&M codes.
• **History Editing Occurs when** a previously submitted historical claim that is related to current claim submission is identified. This identification/edit may result in adjustments to claims previously processed. An example of such a historical auditing action would occur when an E&M visit is submitted on one claim and then a surgery for the same service date is submitted on a different claim. If a determination that the E&M visit paid in history is included in the allowable for the surgery, an adjustment of the E&M claim will be necessary, this may result in an overpayment recovery.

  − History editing capability enables us to auto-adjudicate some of our reimbursement policies including, but not limited to; global surgery, multiple visits per day, pre/post-operative visits, new patient visits, frequency rules incidental, mutually exclusive and rebundle edits and maternity services.

  − This edit will be Effective with claims processed on or after November 7, 2009 with ClaimsXten implementation.

• **Bundled Services and Supplies edits** occur when the editing system identifies certain services and supplies that are considered to be an integral component of the overall medical management service and care of the member and are not reimbursed separately.

  − These services and/or supplies may be reported with another service or as a stand alone service.

  − When reported with another service, modifier 59 will not override the denial for the bundled services and/or supply.

  − Editing for this rule is based on CMS, McKesson and Anthem sourcing.

  − Please refer to Anthems reimbursement policy RE.006 Bundled Services and Supplies.

• **Place of Service edits** identify the reporting of an inappropriate place of service for a particular procedure, either due to the descriptive verbiage of the code, or due to published CPT coding guidelines which indicate that a specific procedure is not intended to be reported in a certain setting.

ClaimCheck® and ClaimsXten® are registered trademarks of McKesson HBOC.

**Clear Claim Connection™**

Clear Claim Connection (CCC) is an online tool available through Anthem’s provider portal, ProviderAccess, that is intended as a tool for evaluating clinical coding information. CCC will provide information according to the claim editing system logic on the date of the provider’s inquiry, and allows providers to view clinically-based information along with documented source information for approximately two million edits. CCC is not a guarantee of member eligibility or claim payment, and is not date-sensitive for the claim date of service. While most of our reimbursement policies are loaded in CCC some are not. CCC is not a guarantee of payment

Sources referenced for the CCC online tool include: American Medical Association Current Procedural Terminology (CPT), CPT Assistant, CPT Coding Symposium, Specialty Society Coding Guidelines and Medicare Guidelines. Not all national accounts, FEP or Medicare Advantage products utilize the claim editing system logic used in Clear Claim Connection, and not all procedure modifiers impact the pricing or processing of procedures (based on Anthem policy).

To access the Clear Claim Connection online tool, go to anthem.com, select Provider and Nevada. From the Provider Home page login to ProviderAccess. Select the Claims tab, and then the Clear Claim Connection link.

Clear Claim Connection™ is a trademark of McKesson.

**Coordination of Benefits and Subrogation**

Coordination of benefits (COB) refers to the process for members receiving full benefits while preventing double payment for services when a member has coverage from two or more sources. The member’s contract outlines which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Providers shall establish procedures for identifying members who have work-related injuries or illnesses or who have other coverage, including auto insurance, that may be coordinated with Anthem coverage. Providers shall use their best efforts to notify Anthem whenever they have reason to believe a member may be entitled to coverage under any other insurance plan, including Medicare, and shall assist Anthem in obtaining COB information when a member holds such other coverage.

Providers agree to make their best effort to identify and notify Anthem of any facts that may be related to auto, workers’ compensation, or third-party injury or illness, and to execute and provide documents that may reasonably be required or appropriate for the purpose of pursuing reimbursement or payment from other payers.
Coordination of Benefits for BlueCard®

If, after calling 800-676-BLUE or through other means you discover that a member’s insurance plan contains a COB provision, and if any Blue Cross and/or Blue Shield plan is the primary payer, please submit the claim(s) along with information about COB to Anthem. If COB information isn’t included with the claim, the member’s plan or the insurance carrier will have to investigate the claim, which will delay claim processing.

Reimbursement Policy

Anthem adjudicates COB claims according to the following guidelines:

- When Anthem is the primary carrier, standard Anthem reimbursement, along with applicable copayments, coinsurance and deductibles, is considered payment in full from Anthem.
- If Medicare is the primary payer, Anthem will use the Medicare allowed amount or the limiting amount (if the Provider didn’t accept Medicare assignment) to determine a secondary payment.
- For PPO and Indemnity claims when Anthem is the secondary carrier and the primary carrier isn't Medicare, the Primary carrier allowance will be used to determine a secondary payment.
- For HMO claims when HMO Nevada is the secondary carrier and:
  - HMO Nevada’s reimbursement is capitation: The Provider has already received payment from HMO Nevada, and this payment fulfills HMO Nevada’s obligations as a secondary carrier. This payment shall be used to cover the member’s obligations under the member’s primary coverage, including any copayment or other liabilities. Therefore, the Provider may not charge the member for any copayment or other liability; if funds are collected from the member, the Provider must reimburse the member for those charges from the Provider’s capitation payment.
  - HMO Nevada’s reimbursement is non-capitated, i.e., some form of fee-for-service: When the primary carrier is not Medicare, the primary carrier allowance will be used to determine a secondary payment. At no time will HMO Nevada pay more as the secondary carrier than it would have paid in the absence of another insurance carrier.
  - Medicare is the primary payer: HMO Nevada will use the Medicare allowed amount or the limiting amount (if the Provider did not accept Medicare assignment) to determine a secondary payment.
- At no time will Anthem pay more as the secondary carrier than it would have paid had it been the primary carrier.

Members with Individual Plan Coverage

Benefit payments for Anthem members with Individual coverage cannot be coordinated with another commercial health insurance, auto medical payments or third-party liability coverage. However, benefits may be coordinated with workers’ compensation or Medicare. Before sending Anthem a refund due to duplicate claims payment, please verify that the refund being submitted is for a member with Group – not Individual – coverage.

Situations When Clinical Information Is Required

The following claims categories may routinely require submission of clinical information before or after payment of a claim:

- Claims involving pre-certification/prior authorization/pre-determination or some other form of utilization review, including, but not limited to the following:
  - Claims pending for lack of pre-certification or prior authorization
  - Claims involving medical necessity or experimental/investigational determinations
  - Claims for pharmaceuticals that require prior authorization
- Claims involving certain modifiers, including, but not limited to, modifier 22
- Claims involving unlisted codes
- Claims for which Anthem can't determine, from the face of the claim, whether it involves a covered service and therefore can't make the benefit determination without reviewing medical records (examples include, but aren't limited to, pre-existing condition issues, emergency service-prudent layperson reviews and specific benefit exclusions)
- Claims Anthem has reason to believe involve inappropriate (including fraudulent) billing
- Claims, including high-dollar claims, that are the subject of an internal or external audit
- Claims for members involved in case management or disease management
• Claims that have been appealed or are otherwise the subject of a dispute, including claims being mediated, arbitrated or litigated

• Other situations in which clinical information may routinely be requested:
  – Requests related to underwriting, including, but not limited to, member or physician misrepresentation/fraud reviews and stop-loss coverage issues
  – Accreditation activities
  – Quality improvement/assurance activities
  – Credentialing
  – Coordination of benefits
  – Recovery/subrogation

Examples provided in each category are for illustrative purposes only and aren’t meant to represent an exhaustive list within the category.
Medical Records Submission Guidelines

Submission of Medical Records for Claims (applies to paper claims only)

Medical records are required for items 1 through 8 below and must be submitted with the claim to help ensure prompt payment of the claim.

1. All miscellaneous HCPCS and CPT codes
2. All miscellaneous J**** codes
3. All IV therapy drugs and home infusion
4. Remicade, Synagis, Synvisc
5. Change of diagnosis (diagnosis code)
6. Unlisted procedures
7. All DME HCPCS codes
8. Endoscopy anesthesia – codes 00740 and 00810

Please note: This list doesn't apply to inpatient facility services.

If medical records aren’t required per the above list, please don’t submit records with the claim.

If medical records are required, please refer to the next section to determine the type of record you must submit.

Medical records previously submitted as part of pre-certification (pre-service review) may meet the requirements for medical records. Please review "Types of Medical Records Required" below.

Types of Medical Records Required (for items 1 through 7 above)

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Medical Record Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>99000 - 99999</td>
<td>Detailed description of services</td>
</tr>
<tr>
<td>01999</td>
<td>Anesthesia record</td>
</tr>
<tr>
<td>10000 - 69999</td>
<td>Operative report or detailed description of services</td>
</tr>
<tr>
<td>70000 - 79999</td>
<td>X-ray report or detailed description of services (operative report)</td>
</tr>
<tr>
<td>80000 - 89999</td>
<td>Lab report or documentation of medical necessity</td>
</tr>
<tr>
<td>90000 - 98000</td>
<td>Office notes or detailed description of services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmaceuticals</th>
<th>Medical Record Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>J3490, J8999, J9999</td>
<td>Name of drug, physician’s orders, NDC code</td>
</tr>
<tr>
<td>Synvisc</td>
<td>Name of drug, physician’s orders, NDC code</td>
</tr>
<tr>
<td>IV therapy (including home infusion)</td>
<td>Name of drug, physician’s orders, NDC code, treatment plan (if applicable)</td>
</tr>
<tr>
<td>Remicade, Synagis</td>
<td>Name of drug, physician’s orders, NDC code, patient’s weight at time of drug administration</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Miscellaneous HCPCS Codes</th>
<th>Medical Record Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1399, L0099 - L9000</td>
<td>Description, order invoice (if applicable)</td>
</tr>
<tr>
<td>Other misc. HCPCS codes</td>
<td>Lab report, test results or documentation of medical necessity, as appropriate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>Medical Record Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>DME HCPCS codes</td>
<td>Documentation of medical necessity and physician’s orders</td>
</tr>
</tbody>
</table>

Additional Medical Records Anthem Also May Request

Some situations may require additional medical records. Although these situations may not have specific rules and guidelines, Anthem will make every attempt to make these requests explicit and limited to the minimal requests necessary to render a decision. Examples include, but aren’t limited to, the following:

- Medical records requested by a member’s Blue Cross and/or Blue Shield Home Plan (national accounts)
- Federal Employee Plan requirements
- Review and investigation of claims (e.g., pre-existing conditions, lifetime benefit exclusions)
- Medical review and evaluation
- Requests for retro authorizations
- Medical management review and evaluation
- Underwriting review and evaluation
- Adjustments
- Appeals
- Quality management (quality of care concerns)
- Records documenting prolonged services