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

Policy Reminder

**Modifier 22: Increased Procedural Service**
*(Policy 07-020, effective 11/01/2017)*

Anthem allows reimbursement for procedure codes appended with Modifier 22. Reimbursement is based on 120 percent of the fee schedule or contracted/negotiated rate when the procedure or service is greater than what is usually required for the listed procedure. The use of Modifier 22 should follow correct coding guidelines for claims submission.

Refer to Modifier 22: Increased Procedural Service reimbursement policy for more information click here.

Policy Updates

**Modifier 63: Procedure Performed on Infants less than 4 kg**
*(Policy 06-015, effective 11/15/2017)*

Currently, Anthem allows additional reimbursement of 120 percent for surgery on neonates and infants up to a present body weight of 4 kg. Effective November 15, 2017, Anthem will allow reimbursement for surgery on neonates and infants up to a present body weight of 4 kg when billed with Modifier 63 at 100 percent of the applicable fee schedule or contracted/negotiated rate for Please note, the neonate weight should be documented clearly in the report for the service. Assistant surgeon and/or multiple procedure rules and fee reductions apply when:

- An assistant surgeon is used
- Multiple procedures are performed on neonates or infants less than 4 kg in the same operative session

**Key Definition**

Modifier 63: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care
professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure.

In applicable circumstances, Anthem does not allow reimbursement for Modifier 63. To view these circumstances, please refer to the Modifier 63: Procedure Performed on Infants less than 4 kg reimbursement policy click here.

**Multiple Radiology Payment Reduction**  
*(Policy 12-002, effective 09/15/2017)*

Anthem allows reimbursement for multiple diagnostic imaging procedures. Multiple diagnostic imaging procedures with the exception of CT scan services will be subject to a Multiple Procedure Payment Reduction (MPPR) when services are performed by the same physician or health care professional with the same National Provider Identifier (NPI) on the same date of service during the same patient encounter.

The global and Technical Component (TC) of certain diagnostic imaging procedures will reimburse at 100 percent of the physician fee schedule or negotiated amount for the service with the highest TC payment. Payment is made at 50 percent for the TC of subsequent services furnished by the same physician to the same patient in the same session on the same day.

A reduced allowance for the second and subsequent procedures will not apply when multiple imaging procedures are billed appended with Modifier 59.

For additional information, please refer to the Multiple Radiology Payment Reduction reimbursement click here.

**Maternity Services**  
*(Policy 14-001, effective 11/15/2017)*

Anthem allows reimbursement for global obstetrical codes once per period of a pregnancy (defined as 279 days) when appropriately billed by a single provider or provider group reporting under the same federal Tax Identification Number (TIN). If a provider or provider group reporting under the same TIN does not provide all Antepartum, Delivery and Postpartum services, global obstetrical codes may not be used and providers are to submit for reimbursement only the elements of the obstetric package that were actually provided. Anthem will not reimburse for duplicate or otherwise overlapping services during the course of the pregnancy.

**What's New?**

We have updated the Maternity Services reimbursement policy to include outcome of delivery/weeks of gestation information. You are required to use the appropriate diagnosis code on professional delivery service claims to indicate the outcome of delivery. Diagnosis codes that indicate the applicable gestational weeks of pregnancy are required on all professional delivery service claims and are recommended for all other pregnancy-related claims. Failure to report the appropriate diagnosis code will result in denial of the claim.

Refer to the Maternity Services reimbursement policy click here.

**Modifier 62: Co-Surgeons**  
*(Policy 06-027, effective 12/15/2017)*

Anthem will not reimburse for the second and subsequent procedures will not apply when multiple imaging procedures are billed appended with Modifier 59.
Anthem allows reimbursement of procedures eligible for co-surgeons when billed with Modifier 62. Each surgeon must bill the same procedure code(s) with Modifier 62. Reimbursement to each surgeon is based on 62.5 percent of the applicable fee schedule or contracted/negotiated rate. Co-surgeons must be from different specialties and performing surgical services during the same operative session.

For more information, please refer to Modifier 62: Co-Surgeons reimbursement policy [click here].

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