

December 1, 2016

Re: Professional Reimbursement Policy Changes and supporting claims editing notification for CMS-1500 submitters

Dear Provider:

Anthem Blue Cross and Blue Shield and our subsidiary company, HMO Colorado (Anthem), is writing to inform you of our new and/or revised reimbursement policies, and to document the new and/or updated rules and edits in our ClaimsXten editing software.

Updates to Claims Processing Edits and Reimbursement Policies

Bundled Services and Supplies and Modifiers 59, XE, XP, XS, and XU – professional

Beginning with dates of service on or after March 1, 2017, we will be implementing the following code pair edits and have documented these edits in our future Bundled Services and Supplies and Modifiers 59, XE, XP, XS, and XU reimbursement policies:

- Current Procedural Terminology (CPT®) code 63048 (*laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; each additional segment, cervical, thoracic, or lumbar*) will not be eligible for separate reimbursement when reported with CPT code 22633 (*arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar*). Modifiers will not override this edit.
- CPT code 22614 (*arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (list separately in addition to code for primary procedure)*) will not be eligible for separate reimbursement when reported with CPT codes 22600 (*arthrodesis, posterior or posterolateral technique, single level; cervical below c2 segment*), 22610 (*arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)*), 22612 (*arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)*), 22630 (*arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar*), and 22633 (*arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar*). Modifiers will not override this edit.
- CPT codes 63081, 63082, 63085, 63086, 68087, and 63088 (*vertebral corpectomies*) will not be eligible for separate reimbursement when reported with CPT code 22558 (*arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar*). Modifiers will not override this edit.
- CPT code 82542 (*column chromatography, includes mass spectrometry, if performed, non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen*) will not be eligible for separate reimbursement when reported with CPT code 91065 (*breath hydrogen or methane test*). Modifiers will not override this edit.
- We consider cervical and vaginal cytopathology to be incidental to evaluation and management (E/M) services. We currently deny CPT codes 88141-88155, 88165-88167, and 88174-88175 as incidental to preventive and problem

oriented E/M services identified by such CPT codes as 99381-99397 and 99201-99215 when reported by the same provider for the same patient on the same date of service. Based on our current edit, we are adding HCPCS codes G0101, G0402, G0438, G0439, S0610 and S0612 (*screening exams, preventive exams, and wellness exams*) as additional support codes that cervical and vaginal cytopathology will not be eligible for separate reimbursement. Modifiers will not override the edit.

- Taking guidance from the February 2016 *CPT Assistant* which states that train-of-four monitoring is bundled with the intraoperative neuromonitoring and should not be separately reported, we are adding an edit that CPT code 95937 (neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method) will not be eligible for separate reimbursement when reported with CPT codes 95940 (*continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes*), 95941 (*continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour*), and G0453 (*continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes*). Modifiers will not override these edits.
- Our current edit denies 76942 (*ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*) as incidental when reported with 76882 (*ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific*).

Based on our interpretation of CPT guidelines that state "Ultrasound guidance procedures also require permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is utilized. Use of ultrasound, without thorough evaluation of organ(s), or anatomic region, image documentation, and final, written report, is not separately reportable", we are updating our edit and will deny 76882 when reported with 76942. Modifiers will not override the edit.

Also, please note that we will be moving our Section 1 code table from our Bundled Services and Supplies policy to a separate document.

Frequency Editing – professional

Beginning with dates of service on or after March 1, 2017, we will be implementing the following frequency limits:

- We consider HCPCS code(s) H0020 (*alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)*) and H0022 (*alcohol and/or drug intervention service (planned facilitation)*) to be "per day" services. Therefore, we will apply a frequency limit of one per date of service to HCPCS codes H0020 and H0022. Modifiers will not override the frequency limit.
- We will apply a frequency limit of one per date of service to CPT code 49185 (*sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed*). This limit is based on our interpretation of CPT parenthetical instruction and the March 2016 *CPT® Assistant Q&A* which state "49185 may only be reported once per day for the treatment of multiple interconnected lesions via single access." Modifiers will not override the frequency limit.
- Based on Center for Disease Control and Prevention (CDC) recommendation, we will apply a frequency limit of three per date of service to CPT codes 87491 (*Chlamydia trachomatis, amplified probe technique*) and 87591 (*Neisseria gonorrhoeae, amplified probe technique*).

Modifiers 59, XE, XP, XS, and XU – professional

Beginning with dates of service on or after March 1, 2017, modifiers will no longer override the following edits:

Our current edit denies 22612 (*arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)*) when reported with 22633 (*arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar*). Based on CPT instruction that states to not report 22633 with 22612. Modifiers will no longer override the edit.

Our current edit denies 63048 (*laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)*) when reported with 22630 (*arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar*). We consider this correct coding; therefore, modifiers will not override the denial.

Our current edit denies CPT code 76942 (*ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*) as incidental to 76881 (*ultrasound, extremity, nonvascular, real-time with image documentation; complete*). We consider this to be correct coding; therefore, modifiers will not override the denial.

Our current edit denies CPT code 42950 (*pharyngoplasty (plastic or reconstructive operation on pharynx)*) as mutually exclusive to CPT code 15757 (*free skin flap with microvascular anastomosis, when a free flap is used to reconstruct both a neck and tongue defect (after laryngectomy or glossectomy)*). We consider this to be correct coding; therefore, modifiers will not override the edit.

Our current edit denies CPT code 27275 (*manipulation, hip joint, requiring general anesthesia*) as incidental to procedures 27093 (*injection procedure for hip arthrography; without anesthesia*) and 27095 (*injection procedure for hip arthrography; with anesthesia*). We consider this correct coding; therefore, modifiers will not override the edits.

Reimbursement Policies are available on our secure provider portal, ProviderAccess:

The new and/or updated policies will be available online December 1, 2016. All professional Reimbursement Policies are located on our secure provider portal, ProviderAccess. Please go to **anthem.com**, and select the **Provider** link in the top center of the page. Select **Colorado** from the drop down list, and **enter**. From the **Provider Home** page, go to the **ProviderAccess Login** tout (blue box on the left side of the page), and select **Medical** from the drop down list and click on the [login](#) button.

Once logged into ProviderAccess, from the **Overview** tab, under the **Policies and Procedures** section, select the link titled **“View Professional Reimb & Admin Policies”**. From the Anthem’s Professional Reimbursement and Administrative Policies overview page, select **Continue**. Select link titled **“Anthem’s Professional Reimbursement & Administrative Policies – By Type”**, then select the **Reimbursement** link, and next the Policy you would like to view.

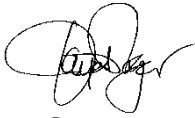
Clear Claim Connection

On the date the new edit becomes effective, Clear Claim Connection, our web-based editing tool, will be updated to incorporate the new editing rules outlined above and will include an interface that will allow you to view the clinical rationale for the edit when you enter claim scenarios. If you have not used Clear Claim Connection previously, we would like to take this opportunity to encourage you to access this user-friendly tool to explore the ClaimsXten edits. Clear Claim

Connection is also located on our secure provider portal, ProviderAccess. Follow the directions listed above to log into ProviderAccess. Once logged in, from the **Claims** tab, select the **Clear Claim Connection** link.

Thank you for your attention to this update. We value and appreciate you as our partner in providing quality care. If you have any questions, please call your Provider Solutions representative. We appreciate your continued participation in our network.

Sincerely,



Janet Pogar
RVP, Provider Engagement and Contracting
Anthem Blue Cross and Blue Shield

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