

Significant Edits for Anthem Blue Cross and Blue Shield (“Anthem”)

A Significant Edit is an edit that, based on experience with submitted claims, will cause, on initial review of submitted claims, the denial or reduction in payment for a particular CPT® code of HCPCS Level II code **more than two-hundred and fifty (250) times** per year in Wisconsin.

The significant edits listing below applies to products Blue Priority (HMO) SM, Blue Preferred®, Primary (HMO), Blue Preferred®, Primary Plus (POS), & Blue Access SM (PPO), Blue Traditional®. Edits are posted on My Anthem at www.anthem.com.

The Significant Edit listing for (state name) is based on a review of historical claims data for claims processed in the prior year and is based on CPT/HCPCS codes in effect during that time. The data reflects the edit logic in place at the time the claims were processed.

This information is for the sole use of our contracted providers and contains confidential and proprietary information. Any unauthorized review, use, disclosure or distribution is prohibited by the terms of your provider agreement with Anthem Blue Cross and Blue Shield.

Inclusion of a procedure code or edit in the list below does not imply or guarantee coverage. Furthermore, Reimbursement Policies/Edits evolve over time, and we reserve the right to review and update these Reimbursement Policies/Edits periodically.

Significant Edit Descriptions

After Hours: CPT 99050 will only be allowed for places of service in the office. All other places of service are denied as part of the global fee. CPT 99051, 99053, 99056, 99058 and 99060 will deny as part of the global fee regardless of place of service.

Anesthesia: Time must be submitted when general anesthesia codes (00100-01999) are billed. When modifiers QY, QK, or QX are billed, the allowance is 50% of the fee schedule allowable.

Assistant Surgeon: For claims processed before 04/15/09:

Modifiers 80, 81, 82 and AS are used on a claim to show that surgical assistant services were provided. Anthem Blue Cross and Blue Shield references Federal Register for Assistant Surgeon reimbursement. If assistant surgery indicator = 0, assistant at surgery will not be paid unless supporting documentation is submitted to establish medical necessity.

If assistant surgery indicator = 1, assistant at surgery will not be paid.

If assistant surgery indicator = 2, assistant at surgery may be paid.

If assistant surgery indicator = 9, concept does not apply.

Assistant Surgeon: For claims processed on or after 04/15/09:

Modifiers 80, 81, 82 and AS are used on a claim to show that surgical assistant services were provided. Anthem Blue Cross and Blue Shield references the American College of Surgeons (ACS) as its primary guide for determining assistant surgeon “always” and “never” designations. When the ACS indicates that an assistant surgeon may “sometimes” be required, or does not assign a designation, we refer to the designations assigned by the Center for Medicare and Medicaid Services (CMS) or our own national Health Care Management physicians. (*Network Update*, Issue 4, 2008)

Global Surgery Days Procedure (Global Days): Anthem Blue Cross and Blue Shield references Federal Register for Global Surgical Procedures.

The Global Surgical Package includes a single payment for major surgical procedures. That payment covers:

- the surgical procedure,
- the preoperative (before surgery) management; and
- the postoperative (after surgery) management.

Global Days:

000 = Endoscopic or minor procedure - visit or services on day of procedure is not payable.

010 = Minor procedure - visit or services on day of procedure and during 10 day postoperative period is not payable.

090 = Major procedure - visit or services with a 1 day preoperative period and 90 day postoperative period is not payable.

MMM = Maternity - There are no pre-op days and for post-op there are 45 days.

XXX = Global surgery rules do not apply to these services.

YYY = Unclassified codes and dental codes - global concept determined on individual consideration basis.

ZZZ = pre- and postoperative work is included in the value for the primary procedure. Therefore pre- and postoperative periods do not apply.

NA = Global period does not apply.

Impression casting for foot orthotic: The charge for the casting or molding for foot orthotics will not be separately reimbursed when an orthotic appliance is billed. The casting or molding is considered to be included in the charges for the orthotic appliance.

Medical Visit: Anthem Blue Cross and Blue Shield follows the CMS guidelines and does not allow separate reimbursement for most Evaluation and Management services when billed on the same day as a significant diagnostic or therapeutic procedure, unless the Evaluation and Management is separately identifiable per the Modifier-25 or -57 guidelines defined in AMA CPT.

Modifier 22: Unusual Procedure Services. When the service provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the procedure code. Upon the provider’s request the central region medical review will review the documentation to determine if the unusual circumstances are documented to support additional reimbursement. Anthem requires submission of documentation to support the unusual circumstances of the procedure. Additional reimbursement for claims submitted with modifier 22 will be allowed only after medical review determines that unusual circumstances are documented in medical record to support additional reimbursement.

Modifier 26: The professional component includes the physician work, overhead and professional liability costs. The technical component includes the cost of equipment, supplies and technician salaries. When professional and technical are billed together it is referred to as the global fee. Codes submitted with Modifier -26 or Modifier-TC when there are no separate RVUs assigned will be denied as part of the global reimbursement.

Multiple Surgery Reduction (Modifier 51): Multiple Surgery logic is applied when multiple procedures or services are performed at the same session by the same provider. If the multiple procedures is bundled into another procedure, separate payment is not allowed unless there is medical documentation supporting rationale for separate payment. If bundling edits are not applied the procedure with the highest maximum allowable amount is considered the primary procedure and is paid based on 100% of the maximum allowable amount. Anthem Blue Cross and Blue Shield references AMA CPT Appendix D add-on codes and allows separate without applying Multiple Surgery Reduction. Anthem Blue Cross and Blue Shield references AMA CPT Appendix E summary of CPT codes exempt without applying Multiple Surgery Reduction.

Pathology Service with Surgical Procedures: Anthem Blue Cross and Blue Shield will not reimburse for pathology services when it is not submitted by the following provider specialties: Dermatology, Anatomical/Clinical Pathology, Dermatopathology, Dermatologic Immunology, Clinical and Lab Immunology, Pediatric Pathology, Cytopathology, Blood banking/transfusion Med, Neuropathology, Forensic Pathology, Immunopathology, Medical Microbiology, Medical Toxicology, Chemical Pathology, Pathology, Oral Pathology and Independent Labs.

Procedure Unbundling: 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.

Same Day Procedure: A global surgical package means to include charges for various services associated with a major surgical procedure into one single payment. The global surgical package generally includes the surgery and the immediate care before and after the surgery. Surgeons usually bill this way. Postoperative care will include Evaluation and Management codes that have the same or similar diagnosis as the diagnosis that is related to the procedure.

Screening Pap Smears with Evaluation and Management including Preventive Medicine The 2008 HCPC Manual reference states that Q0091 (Screening Papanicolaou; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) can be reported with an Evaluation and Management service when a separately identifiable service is provided. To identify when a separate evaluation and management service is required to be submitted along with the Q0091 service, append modifier 25 to the Evaluation and Management service or modifier 59 to Q0091. If the appropriate modifiers are not added then Q0091 will bundle into the Preventive Evaluation and Management services and Non-Preventive Evaluation and Management services will bundle into Q0091.

Single Code Edit: These services and/or supplies may be reported with a primary service or as a stand alone service. Regardless of how they are reported, these services and/or supplies are part of the global reimbursement and not reimbursed separately. These bundled services and supplies may include, but are not limited to:

- **Procedure 99140:** 99140 is paid at a flat fee. CPT code 99140 is not paid when submitted with certain maternity diagnosis codes.
- administrative services requiring physician documentation (e.g. recertification, release forms, physical/camp/school/daycare forms, etc.)
- all practice overhead costs, such as heat, light, safe access, regulatory compliance including CDC and OSHA compliance, general supplies (paper, gauze, band aids, etc.), insurance (including malpractice insurance), collections
- collection/analysis of digitally/computer stored data
- computer aided detection with chest radiography
- copies of test results for patient
- costs to perform participating provider agreement requirements, such as prior authorizations, appeals, notices of non coverage
- determination of venous pressure
- DME delivery and/or set up fees
- handling and/or conveyance fees
- heparin lock flush solution or kit for non therapeutic use
- insertion of a pain pump by the operating physician during a surgical procedure
- peak expiratory flow rate
- photography
- pharmacy dispensing services and/or supply fees, etc.
- physician care plan oversight
- post op follow up visit during the global period for reasons related to the original surgery
- prescriptions, electronic, fax or hard copy, new and renewal, including early renewal
- pulse oximetry
- recording or generation of automated data
- review of medical records
- robotic surgical system
- routine post surgical services such as dressing changes and suture removal
- supplemental tracking codes for performance measurement (Category II CPT¹ Codes)
- surgical/procedural supplies and materials supplied by the provider rendering the primary service (e.g. surgical trays, syringes/needles, sterile water etc.)
- telephone consultations with the patient, family members, or other health care professionals
- team conferences to coordinate patient care

The following table identifies by code some of the procedures and supplies that are described above. The inclusion or exclusion of a specific code does not indicate eligibility for coverage under all circumstances. This table is provided as an informational tool only, to help identify some of the procedures described above.

0174T	93770	98968	99058	99340	99367	99378	A4262	H0048
0175T	94005	99002	99060	99358	99368	99379	A4263	J1642
0185T	94760	99024	99070	99359	99374	99380	A4270	S2900
15850	94761	99051	99090	99361	99375	99441	A4300	S3600
78890	98966	99053	99091	99362	99376	99442	A4550	S3601
78891	98967	99056	99339	99366	99377	99443	G0269	S8110
A4649								

Surgical Trays: Anthem Blue Cross and Blue Shield uses the resource based relative value scale (RBRVS) as a guide for reimbursement. Under RBRVS, the supply costs for procedures are included in the practice expense relative value units (RVUs). A4550, in the office setting is not separately reimbursed.

Incidental: An Incidental Procedure is performed at the same time as a more complex primary procedure. The incidental procedure does not require significant, additional physician resources and/or is clinically integral to the performance of the primary procedure.

Allowed Code	Denied/Reduced Code	
10060	90772	Incidental
17000	11100	Incidental
17110	11300	Incidental
20550	90772	Incidental
20552	90772	Incidental
20610	20550	Incidental
20610	20551	Incidental
20610	90772	Incidental
29881	29877	Incidental
38221	38220	Incidental
43239	99144	Incidental
45378	99144	Incidental
45380	99144	Incidental
45385	45380	Incidental
45385	99144	Incidental
51726	51701	Incidental
51741	51701	Incidental
54150	64450	Incidental
55700	64450	Incidental
57288	52000	Incidental
58563	64435	Incidental
58563	90772	Incidental
58565	64435	Incidental
69210	90772	Incidental
69210	92504	Incidental

Allowed Code	Denied/Reduced Code	
70496	70450	Incidental
71020	71010	Incidental
72010	72040	Incidental
72010	72070	Incidental
72010	72100	Incidental
76831	76830	Incidental
78465	36000	Incidental
78465	90765	Incidental
78465	90774	Incidental
80050	80053	Incidental
80050	84443	Incidental
80050	85025	Incidental
80051	82435	Incidental
80051	84132	Incidental
80051	84295	Incidental
80053	82040	Incidental
80053	82247	Incidental
80061	82465	Incidental
80061	83718	Incidental
80061	83721	Incidental
80076	82040	Incidental
80076	82247	Incidental
80076	82248	Incidental
80076	84075	Incidental
80100	80101	Incidental
81000	81002	Incidental
81001	81003	Incidental
81002	83986	Incidental
81003	83986	Incidental
82270	82272	Incidental
82465	83721	Incidental
82962	82947	Incidental
84439	84479	Incidental
84481	84480	Incidental
85025	85007	Incidental
85025	85014	Incidental
85025	85018	Incidental
85025	85027	Incidental
85025	85032	Incidental
85730	80500	Incidental
86580	90772	Incidental
87184	87186	Incidental

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Allowed Code	Denied/Reduced Code	
88175	G0123	Incidental
90465	90467	Incidental
90471	90473	Incidental
90765	99211	Incidental
90766	36000	Incidental
90775	36000	Incidental
90775	96523	Incidental
92135	92250	Incidental
92508	92507	Incidental
92557	69210	Incidental
92567	69210	Incidental
92980	93508	Incidental
92980	93555	Incidental
92980	93556	Incidental
93000	93040	Incidental
93010	93042	Incidental
93015	36000	Incidental
93015	90774	Incidental
93015	90775	Incidental
93015	93000	Incidental
93016	93010	Incidental
93307	90774	Incidental
93720	94360	Incidental
94010	94150	Incidental
94010	94200	Incidental
94010	94375	Incidental
94060	90772	Incidental
94060	94010	Incidental
94060	94150	Incidental
94060	94200	Incidental
94060	94375	Incidental
94060	94640	Incidental
94060	94664	Incidental
94070	94060	Incidental
94640	94664	Incidental
94725	94720	Incidental
95115	90772	Incidental
95117	90772	Incidental
96101	96103	Incidental
96413	36000	Incidental
96413	96523	Incidental
97024	97026	Incidental

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Allowed Code	Denied/Reduced Code	
97035	97024	Incidental
97110	97002	Incidental
97110	97010	Incidental
97140	95851	Incidental
97140	97018	Incidental
98925	90772	Incidental
98925	99213	Incidental
98940	97112	Incidental
98940	97124	Incidental
98940	99202	Incidental
98940	99203	Incidental
98940	99213	Incidental
98941	97112	Incidental
98941	97124	Incidental
98941	99201	Incidental
98941	99202	Incidental
98941	99203	Incidental
98941	99211	Incidental
99144	90760	Incidental
99144	90774	Incidental
99202	94760	Incidental
99203	94760	Incidental
99203	A4649	Incidental
99204	94760	Incidental
99211	94760	Incidental
99211	96523	Incidental
99211	A4208	Incidental
99211	A4245	Incidental
99212	94760	Incidental
99212	A4206	Incidental
99213	81002	Incidental
99213	93010	Incidental
99213	94760	Incidental
99213	94761	Incidental
99213	99173	Incidental
99213	A4206	Incidental
99213	A4208	Incidental
99214	36410	Incidental
99214	93010	Incidental
99214	94760	Incidental
99214	94761	Incidental
99214	99173	Incidental

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Allowed Code	Denied/Reduced Code	
99214	A4209	Incidental
99214	A4215	Incidental
99214	A4649	Incidental
99215	94760	Incidental
99220	93010	Incidental
99223	93010	Incidental
99232	93010	Incidental
99233	93010	Incidental
99233	94761	Incidental
99243	94760	Incidental
99244	93010	Incidental
99244	94760	Incidental
99245	94760	Incidental
99283	94760	Incidental
99284	94760	Incidental
99285	93010	Incidental
99285	94760	Incidental
99385	Q0091	Incidental
99386	Q0091	Incidental
99391	A4208	Incidental
99391	A4215	Incidental
99392	A4206	Incidental
99392	A4208	Incidental
99395	Q0091	Incidental
99396	Q0091	Incidental
A0427	A0422	Incidental
A0429	A0382	Incidental
A0429	A0422	Incidental
Q0091	99213	Incidental
Q0091	99214	Incidental

Mutually Exclusive: 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.

Allowed Code	Denied/Reduced Code	
77080	77081	Mutually Exclusive
77081	77082	Mutually Exclusive
93720	94260	Mutually Exclusive
94240	94260	Mutually Exclusive

Allowed Code	Denied/Reduced Code	
95115	99211	Mutually Exclusive
95115	99213	Mutually Exclusive
95117	99211	Mutually Exclusive
95117	99213	Mutually Exclusive
99213	88175	Mutually Exclusive
99213	99203	Mutually Exclusive
99385	88175	Mutually Exclusive
99395	88142	Mutually Exclusive
99395	88175	Mutually Exclusive
99396	88175	Mutually Exclusive
99396	99213	Mutually Exclusive

Age Edits: 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.

Allowed Code	Denied/Reduced Code	
N/A	90465	Age edits
N/A	90466	Age edits
N/A	90467	Age edits
N/A	90649	Age edits
N/A	90655	Age edits
N/A	90656	Age edits
N/A	90657	Age edits
N/A	90658	Age edits
N/A	90660	Age edits
N/A	90669	Age edits
N/A	90736	Age edits
N/A	99381	Age edits
N/A	99385	Age edits
N/A	99391	Age edits
N/A	99392	Age edits
N/A	99393	Age edits
N/A	99394	Age edits
N/A	99395	Age edits
N/A	99396	Age edits
N/A	99397	Age edits
N/A	99431	Age edits
N/A	99433	Age edits

Significant Modifiers based on Claims experience are as follows:

50 Bilateral procedure: Services that are performed on both sides of the body in the same operative session by the same healthcare provider.

52 Reduced Services: Used to indicate that, under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's discretion. Also, it is used to indicate that a procedure or service is being performed at a lesser level.

54 Surgical Care only: This modifier is to be billed by a physician who performs the surgical procedure. It is used when a different physician performs the preoperative and/or postoperative management.

62 Two surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any add-on codes(s) as long as both surgeons continue to work together as primary surgeons.

80 Assistant Surgeon: Surgical assistant services were provided.

81 Minimum Assistant Surgeon: Minimum surgical assistant services were provided.

82 Assistant Surgeon: A qualified resident surgeon was not available for assistance at surgery.

AS Assistant Surgeon: Assistant at surgery services was provided by a physician assistant, nurse practitioner, registered nurse first assistant or clinical nurse specialist.

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