Provider Reimbursement Policy Bulletin
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Anthem. HealthKeepers Plus
Offered by HealthKeepers, Inc.

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Anthem HealthKeepers Plus 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 HealthKeepers Plus Reimbursement Policies, visit our website at [mediproviders.anthem.com/va/pages/reimbursementpolicies.aspx].

Policy Updates

Allergy Treatment: Immunotherapy

(Policy 06-110, originally effective 11/01/2013)

Reimbursement is allowed up to 20 doses billed for preparation of single or multiple antigen doses for a 30-day period. Claims billed for more than 240 doses during a 12-month period will be denied.

Consultations

(Policy 05-006, originally effective 11/01/2013)

Reimbursement is not allowed when a transfer of care to the consulting provider occurs (i.e., subsequent visits for the same patient by the same consulting provider).

Requirement for Documentation of Proof of Timely Filing

(Policy 06-133, originally effective 11/01/2013)

Reimbursement of a claim that is denied for failure to meet timely filing requirements will be reconsidered when a provider can provide a date of claim receipt compliant with applicable timely filing requirements or demonstrate that good cause exists.

Drugs and Injectable Limits

(Policy 12-003, originally effective 11/01/2013)

Reimbursement is allowed for drug claims received with HCPCS/CPT procedure codes that do not contain Medically Unlikely Edit (MUE) limits and are within the physical quantities of drugs, also known as units. The Centers for Medicare and Medicaid Services (CMS) MUE value is utilized. When there is no MUE assigned by CMS, identified codes will have a Clinical Unit Limits (CUL) assigned or calculated based on the prescribing information, United States Food and Drug Administration and established reference compendia. Claims that exceed the CUL will be reviewed for documentation to support the additional units. If the documentation does not support the additional units billed, all units will be denied.

Anesthesia

(Policy 07-018, originally effective 11/01/2013)

Reimbursement is allowed for professional neuraxial epidural anesthesia services provided in conjunction with labor and delivery for up to 300 minutes by either the delivering physician or a qualified provider

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other than the delivering physician based on the time the provider is physically present with the member.

Additional documentation must be submitted upon dispute for consideration of reimbursement of time in excess of 300 minutes. Reimbursement is based on one of the following:

- For the delivering physician – based on a flat rate or fee schedule using the surgical CPT pain management codes for epidural analgesia
- For a qualified provider other than the delivering physician – based on:
  - The allowance calculation
  - Inclusive of catheter insertion and anesthesia administration

Other Provider Preventable Conditions

(Policy 12-006, originally effective 11/01/2013)

Other Provider Preventable Conditions (OPPC) are not reimbursable; procedures identified as OPPC will be rejected or denied.

[NOTE: CMS has identified that some providers are using the PC modifier to represent the professional component of a service. This is incorrect. The PC modifier is defined as Wrong Surgery on a Patient. The incorrect use of this modifier results in claims being incorrectly denied. HealthKeepers, Inc. will require the provider submit a corrected claim indicating the appropriate coding for the service(s) rendered.]

Portable/Mobile/Hand-held Radiology

(Policy 06-160, originally effective 11/01/2013)

Reimbursement is allowed for portable/mobile radiology services when furnished in a residence used as the patient's home if ordered by a physician and performed by qualified portable radiology suppliers. Portable/mobile radiology studies should not be performed for routine purposes or for reasons of convenience. Reimbursement is based on the applicable fee schedule or contracted/ negotiated rate for the radiological service, and transportation and setup components with the use of applicable modifiers.

[NOTE: Portable radiology suppliers must be licensed or registered to perform services as required by applicable state laws.]

Documentation Standards for Episodes of Care

(Policy 11-004, originally effective 11/01/2013)

Providers may be requested to submit additional documentation, including medical records or other documentation not directly related to the member, to support claims submitted. If documentation is not provided following the request or notification, or if documentation does not support the services billed for the episode of care, the claim may be denied or monies previously covered on the claim may be recovered and/or recouped.

Duplicate or Subsequent Services on Same Date of Service

(Policy 06-032, originally effective 11/01/2013)

Reimbursement of duplicate or subsequent services is based on the correct usage of the below modifiers which indicate the service

was appropriately repeated or additionally billed for the same member:

- Modifier 62: Co-Surgeons
- Modifier 66: Surgical Teams
- Modifier 76: Repeat Procedure by the Same Physician
- Modifier 77: Repeat Procedure by Another Physician
- Modifier 80: Assistant at Surgery providing full assistance to the primary surgeon
- Modifier 81: Assistant at Surgery providing minimal assistance to the primary surgeon
- Modifier 82: Assistant at Surgery, when a qualified resident surgeon is not available to assist the primary surgeon
- Modifier AS: Assistant at Surgery who is a non-physician (e.g., physician assistant, nurse practitioner)
- Modifier 91: Repeat Clinical Diagnostic Laboratory Test
- Modifier GG: Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day
- Modifier GH: Diagnostic mammogram converted from screening mammogram on same day

Reimbursement of Claims with Charge Discrepancies

(Policy 06-132, originally effective 11/01/2013)

Claims submitted with an itemized statement where there is a discrepancy in total charges less than $100 is allowed for reimbursement.

Itemized claims with discrepancies totaling more than $100 or claims submitted that are not itemized and contain a discrepancy between the line item and the total amount billed will be denied and returned to the provider as an unclean claim. The provider will be required to resubmit a corrected claim for reimbursement.

To view specific criteria, refer to the list of reimbursement policies at mediproviders.anthem.com/va/pages/reimbursementpolicies.aspx. Your continued feedback is critical to our success. If you have questions, call your Network Manager or our Provider Services team at 800-901-0200.