Reimbursement Policy bulletin

December 2014, Issue 1

New policies

Inpatient Readmissions
(Policy 13-002, effective 04/01/15)

Anthem Blue Cross and Blue Shield (Anthem) does not allow separate reimbursement for claims that have been identified as a readmission to the same hospital for the same, similar or related condition. In the absence of mandates, Anthem will use the following standards:

- Readmission up to 30-days from discharge
- Same diagnosis or diagnoses that fall into the same grouping

Readmissions occurring on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition are considered part of the original admission and will be combined. Anthem considers a readmission to the same hospital for the same, similar or related condition on the same date of service to be a continuation of initial treatment.

Anthem will use clinical criteria and licensed clinical medical review for readmissions from days 2 to 30 in order to determine if the second admission is for:

- The same or closely related condition or procedure as the prior discharge
- An infection or other complication of care
- A condition or procedure indicative of a failed surgical intervention
- An acute decompensation of a coexisting chronic disease
- A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period
- An issue caused by a premature discharge from the same facility
- A reason that is medically unnecessary

Anthem reserves the right to recoup and/or recover monies previously paid on a claim that falls within the guidelines of a readmission for a same, similar or related condition as defined above.

Exclusions:

- Admissions for the medical treatment of cancer, primary psychiatric disease and rehabilitation care
- Planned readmissions
- Patient transfers from one acute care hospital to another
- Patient discharged from the hospital against medical advice

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Inpatient Facility Transfers
(Policy 13-002, effective 04/01/15)

Anthem allows payment for services rendered by both the sending and the receiving facility when a patient is admitted to one acute care facility and subsequently transferred to another acute care facility for same episode of care, in compliance with federal and/or state guidelines regarding facility transfers payment.

Both the transferring and receiving facility will receive the full diagnosis related group (DRG) amount.

Maternity Services
(Policy 14-001, effective 04/01/15)

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). Reimbursement is based on all aspects of the global obstetric care package (antepartum, delivery and postpartum). In the event 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. Providers can elect reimbursement for Maternity Services on either a global basis or as individual services. Payment methodologies may not be mixed. We will not reimburse for duplicate or otherwise overlapping services during the course of the same pregnancy.

Policy updates

Preadmission Services for Inpatient Stays
(Policy 07-017, originally effective 07/01/14)

Anthem allows reimbursement for applicable services for a covered member prior to admission to an inpatient hospital (referred to as the payment window). For admitting hospitals, applicable preadmission services are included in the inpatient reimbursement for the three days prior to and including the day of the member’s admission, and therefore are not separately reimbursable expenses. For other hospitals and units, applicable preadmission services are included in the inpatient reimbursement within one day prior to and including the day of the member’s admission and, therefore, are not separately reimbursable expenses. For critical access hospitals, outpatient diagnostic services are not subject to either the three day or one day payment window and, therefore, are separately reimbursable expenses from the inpatient stay reimbursement.

Please note, the three day or one day payment window does not apply to outpatient diagnostic services included in the rural health clinic or federally qualified health center all-inclusive rate.

Applicable preadmission services consist of all diagnostic outpatient services (including non-patient laboratory tests) and clinically related nondiagnostic services that are related to the inpatient stay and are included in the inpatient reimbursement. A hospital may attest to specific nondiagnostic services as being unrelated by adding a condition code 51 to the outpatient nondiagnostic service to be billed separately.

Prosthetic and Orthotic Devices
(Policy 06-084, originally effective 07/01/14)

Reimbursement is allowed for prosthetic and orthotic devices when provided as part of a physician's services or ordered by a physician and used in accepted medical practice. Reimbursement is based on the applicable fee schedule or contracted/ negotiated rate for the prosthetic or orthotic device dispensed. The design, materials, measurements, fabrications, testing, fitting and training in the use of the device are included in the reimbursement of the device and are not separately reimbursable expenses. In instances of theft, a police report is required for consideration of replacements.

Transportation Services: Ambulance and Non-Emergent Transport
(Policy 07-036, originally effective 07/01/14)

Anthem allows reimbursement for transport to and from covered services or other services mandated by contract. Due to the complex nature of transportation services, Anthem recommends that providers also review individual state guidelines for coverage requirements. Please note, Anthem does not allow reimbursement for mileage when the ambulance transport service has been denied or is not covered.

Split-Care Surgical Modifiers
(*Policy 11-005, originally effective 07/01/14*)

Reimbursement of **surgical codes** appended with "split-care modifiers," is allowed and based on a percentage of the fee schedule or contracted/negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code:

- Modifier 54 (surgical care only): 80 percent
- Modifier 55 (postoperative management only): 20 percent

Included in the global surgical package are preoperative services, surgical procedures, and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's care.
As a reminder, claims received with split-care modifiers after a global surgical claim have been paid will be denied. Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

Policy reminder

Modifier 22: Increased Procedural Service
(Policy 07-020, originally effective 07/01/14)

Anthem does not allow additional reimbursement for procedure codes appended with Modifier 22 when the procedure or service provided is greater than what is usually required for the listed procedure code.

To view additional policy specific information and all Anthem reimbursement policies, visit **www.anthem.com/wimedicaiddoc.**