Commercial Reimbursement Policy

Subject: **Code and Clinical Editing Guidelines - Professional**	
Policy Number: **C-09004**	Policy Section: **Administration**
Last Approval Date: **04/01/2024**	Effective Date: **07/01/2024**

Disclaimer

These reimbursement 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 an Anthem Blue Cross (Anthem) member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, Anthem will publish the most current policy to the website.

Policy

The Health Plan applies Code and Clinical Editing Guidelines (CCEG) to evaluate claims for accuracy and adherence to accepted national industry standards and plan benefits unless provider, state, federal, or contracts indicate otherwise.

The Health Plan uses software products that ensure compliance with standard code edits and rules. These products increase consistency of payment for providers by

ensuring correct coding and billing practices and may automatically apply edits using the software's editing logic. CCEG consists of the following measures:

- Code editing software, CMS National Correct Coding Initiative (NCCI) edits and Outpatient Code Edits (OCE)
  - Code editing software is updated to conform to changes in coding standards
  - National Correct Coding Initiative (NCCI) edits are updated according to CMS published updates:
    - PTP (procedure to procedure)
    - MUE (Medically Unlikely Edits)
- Clinical criteria
- Claims processing platform
- Per state requirements, the Health Plan publishes the use of specific commercial code editing software
- The Health Plan only customize applicable CCEG measures due to compelling business reasons

The Health Plan also uses a coding algorithm approach to automatically adjudicate Evaluation and Management claims based on the applicable level of complexity or severity in accordance with diagnosis codes reported on the claims.

CCEG measures are updated as applicable and as needed to incorporate new codes, code definition changes, and edit rule changes.

All claims submitted after the configuration implementation date, regardless of service date, will be processed according to up-to-date CCEG measures. No retrospective payment changes, adjustments, and/or requests for refunds will be made when processing changes are a result of new code editing rules within a module update. The member is not responsible and should not be balance billed for any procedures for which payment has been denied or reduced as the result of CCEG measures. Please refer to the Health Plan's reimbursement policies for specific reimbursement rules.

Nonreimbursable

The Health Plan will not reimburse in the event of a conflict with CCEG.

Note: When a service unit exceeds an MUE, the claim line(s) will be denied.

The procedures listed below are not eligible for reimbursement with the reported diagnosis code or service in accordance with the Health Plan's professional reimbursement policies and/or correct coding guidelines:

Related Coding

Description	Comments
Codes Not Eligible for Reimbursement	Codes Not Eligible for Reimbursement Based on Diagnosis

Based on Diagnosis	

Policy History

04/01/2024	Review approved 04/01/2024 and effective 07/01/2024: added language regarding CMS MUE
09/08/2022	Review approved: added coding link to Related Coding section
10/01/2020	Removed 10/01/2020 and effective 01/1/2021: *Deny osteotomy codes 22206, 22207 22208, 22210, 22212, 22214, 22216, 22220, 22222, 22224, and 22226 reported with a diagnosis other than kyphosis (M40.XXX) or scoliosis (M41.XXX); p*olicy title changed, policy updated to removed detailed language that already exists in related reimbursement policies, removed Medicare Advantage disclaimer, removed definitions that are no longer relevant; added language referencing coding algorithms
06/01/2019	Policy template updated
12/07/2018	Policy language updated to expand the definition of same provider
03/23/2018	Review: removed specific code editing software brand names and added related policies section
02/07/2017	Policy language added under “Frequency” section to match language in the “Frequency Editing” policy.
03/07/2017	Policy language updated; added specific codes for spinal osteotomy codes that are not eligible for reimbursement.
05/02/2017	Policy language updated; revised last bullet under policy section I to read, “When a denial is received on a remittance, review the edit descriptions listed below and review the coding for the submitted claim prior to initiating an appeal”.
08/01/2017	Policy language updated; added language to Technical/Professional billing section for associated providers within the same group/TIN
06/07/2016	Policy language updated; removed references to gender for gender reassignment surgeries.
10/04/2016	Policy language updated; removed all references to ICD-9, added language for multiple diagnostic ophthalmology and diagnostic cardiovascular services
08/04/2015	Policy language updated; specific references to editing software were removed throughout the policy and revision of the definition of a ‘new patient’
10/06/2015	Policy language updated; ‘professional’ added throughout the policy to distinguish between professional and facility reimbursement policies.
04/07/2015	Review: minor revisions to policy included adding ‘X’ modifiers to non-site specific modifiers and added a new paragraph for different providers billing separately for global and technical or professional components of lab procedures.

04/01/2014	Policy language updated; References to diagnosis codes were updated throughout the policy to include ICD-10.
02/05/2013	Policy language updated; included administrative updates along with adding a section for multiple surgeries and revised audit language under Section I. Documentation and Reporting.
03/05/2013	Policy language updated; included administrative updates along with clarifying the definition of 'new patient'
07/02/2013	Annual Review: bracketed language added for exemptions, ICD-9 age symbols, heading changes to bundled services section, definition of customized edit and added a section for multiple diagnostic imaging.
04/03/2012	Policy language updated; specific language added to DME section to included rented items and added modifier 59 language.
06/05/2012	Policy language updated; deleted language referencing duplicate line items and added language for Standard Multiple Surgery Reimbursement
08/07/2012	Policy language updated to add description to NCCI edits for columns 1 and 2 and added language for non-site specific modifiers that can override NCCI edits.
07/12/2011	Review: Deleted reference to migration from process date to date of service and added language to reflect quarterly updates to editing system.
07/06/2010	Policy language updated to include Clear Claim Connection statement. "Actual claims results may differ from inquiry"
11/03/2009	Policy language updated for the following sections: bilateral billing, pre-op/post-op services and technical/professional component billing.
04/07/2009	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS (Centers for Medicaid and Medicare Services)
- NCCI (National Correct Coding Initiative)
- Optum EncoderPro 2022

Definitions

Editing	The practice or procedure pursuant to which one or more adjustments are made to CPT® codes or HCPCS codes included in a claim that result in: • payment being made based on some, but not all, of the CPT®/HCPCS′ codes included in the claim • payment being made based on different CPT®/HCPCS codes than those included in the claim • payment for one or more of the CPT®/HCPCS codes included in the claim being lowered by application of multiple procedure logic

	• payment for one or more of the CPT®/HCPCS codes being denied, or any combination of the above
General Reimbursement Policy Definitions	

Related Policies and Materials

After-Hours, Emergency, and Miscellaneous E/M Services – Professional and Facility
Assistant at Surgery (Modifiers 80, 81, 82, AS) - Professional
Bundled Services and Supplies - Professional
Evaluation and Management Services and Related Modifiers -25 and -57
Frequency Editing - Professional
Global Surgery - Professional
Health and Behavior Assessment and Intervention - Professional
Injection and Infusion Administration and Related Services and Supplies - Professional
Laboratory and Venipuncture Services – Professional and Facility
Modifier Rules - Professional
Multiple and Bilateral Surgery Processing - Professional
Multiple Diagnostic Imaging Procedures - Professional
Place of Service - Professional
Professional Anesthesia Services - Professional
Screening Services with Related Evaluation and Management Services - Professional

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving, and we reserve the right to review and update these policies periodically.