Commercial Reimbursement Policy

Subject: **Once-per-Lifetime Procedures – Professional**	
Policy Number: **C-15003**	Policy Section: **Coding**
Last Approval Date: **02/14/2024**	Effective Date: **02/14/2024**

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 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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, we will publish the most current policy to the website.

Policy

Anthem does not allow reimbursement for once-per-lifetime procedures if a historical claim with the same procedure, or a procedure from the same code family, is identified unless provider, state, or federal contracts and/or mandates indicate otherwise.

Anthem considers once-per-lifetime procedures as procedures that can be performed only once on an individual patient by a physician(s) or other qualified healthcare provider(s) based on clinical, anatomical, code description, or coding instructions.

A historical claim includes once-per-lifetime procedures that have been processed and approved by a previous carrier or Elevance-affiliated health plan.

Note: Anthem allows once-per-lifetime procedures when billed with an appropriate modifier.

Related Coding

Description	Coding Grid	Comments
Once-per-lifetime procedure codes arranged by code family	Once-per-lifetime procedure codes arranged by code family	The inclusion or exclusion of a specific code does not indicate eligibility for reimbursement under all circumstances.

Policy History

02/14/2024	Review approved and effective: updated coding grid
09/15/2020	Review approved: minor administrative changes made; modifiers removed; code list expanded and added as an attachment; removed *Medicare Advantage disclaimer*
06/01/2019	New policy template: removed D*escription section* and added Definition section
05/04/2018	Review approved 05/04/2018 and effective 08/01/2018: modifier 58 removed
10/04/2016	Review approved: language updated for clarity; no changes made to the policy criteria; added surgical assistant modifiers
09/01/2015	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- American Medical Association (AMA) Current Procedural Terminology (CPT®) Professional Edition 2022

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

Global Surgery Package – Professional
Modifier Usage – Professional

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.