

Claims Processing Significant Edits

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Inclusion of a procedure code or edit within this document 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. Edits for state-sponsored programs are mandated by the State. The State updates requirements periodically and they are subject to change.

An Edit is a practice or procedure pursuant to which one or more adjustments are made to CPT[®] Codes or HCPCS Level II Codes included in a claim that result in (a) payment being made based on some, but not all, of the CPT[®] Codes or HCPCS Level II Codes included in the claim, (b) payment being made based upon different CPT[®] Codes or HCPCS Level II Codes than those included in the claim, (c) payment for one or more of the CPT[®] Codes or HCPCS Level II Codes included in the claim being reduced by application of Multiple Procedure Logic, (d) payment for one or more of the CPT[®] Codes or HCPCS Level II Codes being denied, or (e) any combination of the above.

An incidental procedure is performed at the same time as another primary procedure, and the payment is considered inclusive with the primary procedure. Codes considered incidental if billed separately or in combination with any other codes will always be denied as incidental.

Significant Edits

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 or HCPCS Level II code more than two hundred fifty (250) times per year.

The Significant Edit listing is based on a review of historical claims data for claims processed 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. For Anthem Blue Cross and Blue Shield's State-Sponsored Business within Indiana, the significant incidental edits are:

Office Visits rendered on an Outpatient Setting, Place of Service 22 / 23 / 62:

Procedures performed in an outpatient setting or place of service 22, 23, or 62, are subject to site of service payment adjustment, which is 80% of the practice expense component of the statewide RBRVS IHCP Fee Schedule. These procedures are identified with a site of service indicator on the Medicare Fee Schedule database:

CPT Codes 99201 – 99205 – New patient Office or other outpatient visit

CPT Codes 99211 – 99215 – Established Patient – Office or other outpatient visit

Physician Assisting Another Physician: Modifier 80 is used on a claim to show that assistant physician services were provided. Anthem Blue Cross and Blue Shield

references the CMS guidelines to determine if an assistant physician may be paid or will not be paid.

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. 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 CMS physician fee schedule and allows separate without applying Multiple Surgery Reduction. Anthem Blue Cross and Blue Shield references CMS physician fee schedule to identify CPT codes exempt without applying Multiple Surgery Reduction.

Bilateral Surgery Reduction (Modifier 50): Bilateral Surgery logic is applied when bilateral procedures or services are performed at the same session by the same provider and are reimbursed at 150%.