April 18, 2009

Dear Provider:

As we communicated to you last year, we implemented ClaimsXten™, our new claims editing tool, in July 2008. ClaimsXten has allowed us to achieve consistency with nationally accepted coding guidelines and other payers in the industry as well as to facilitate accurate, efficient claims processing. As in previous correspondence, we are taking the opportunity to notify you of upcoming changes to our claims editing rules. Claims submitted in a CMS-1500 format and processed on or after July 18, 2009 will be subject to the editing rules that are summarized below and can be viewed with accompanying clinical rationale on our web site through Clear Claim Connection™.

Summary of Changes

1. Multiple Endoscopic and Arthroscopic Surgical Procedures

   Endoscopic and arthroscopic surgical procedures with the same base code (per the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule RVU File) will be reimbursed at 100 percent (100%) for the primary procedure and at a reduced percentage for each subsequent procedure when performed at the same operative session, with the same base code. The impacted procedure code ranges and corresponding reimbursement percentages will be as follows:

Base Code	Procedure Code Ranges	Reimbursement Percentages
Shoulder Arthroscopy	29805–29828	100% primary; 30% subsequent
Elbow Arthroscopy	29830–29838	100% primary; 25% subsequent
Wrist Arthroscopy	29840–29847	100% primary; 25% subsequent
Hip Arthroscopy	29860–29863	100% primary; 25% subsequent
Knee Arthroscopy	29870–29887	100% primary; 35% subsequent

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Base Code	Procedure Code Ranges	Reimbursement Percentages
Bronchoscopy	31622-31631, 31635-31636, 31638-31641, 31645	100% primary; 25% subsequent
Upper GI Endoscopy	43231-43232 43235-43259	100% primary; 25% subsequent
Colonoscopy	45378–45392	100% primary; 25% subsequent
Endoscopic Retrograde Cholangiopancreatography (ERCP)	43260-43272	100% primary; 25% subsequent

Consistent with current processing, other endoscopy and arthroscopy code families and surgery procedures, not specified above, will be reimbursed subject to the multiple surgery reduction (MSR) policy of 100% for the primary and 50% for each payable subsequent procedure.

The primary surgery designation for a multiple surgery claim will be based on the code with the highest relative value based on CMS National Physician Fee Schedule Relative Value File using (1) either facility or non-facility relative value based on the place of service or (2) the appropriate facility or non-facility relative value will be determined based on the place of service billed for the procedure.

2. Laboratory Combination Processing

   Individual lab tests that are part of a panel code will be rebundled into the applicable panel codes as defined by AMA CPT whether or not all of the individual lab tests of the panel are billed. This edit takes into account the aggregate reimbursement for the individual lab tests reported which should not exceed the reimbursement amount for the panel code. For example: an Electrolyte Panel (CPT 80051) is comprised of the following laboratory tests: Carbon dioxide (82374), chloride (82435), potassium (84132) and sodium (84295). This edit will rebundle to 80051 when two or more of the individual tests are billed for the same member and same date of service when the aggregate reimbursement for the individual tests is greater than the panel code 80051.

3. Multiple Cardiac Catheterization Procedures

   Cardiac catheterization procedures will be reimbursed, subject to the multiple surgery reduction (MSR) policy, at 100 percent (100%) for the primary procedure and 50 percent (50%) for each subsequent procedure when performed during the same session.

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4. Multiple Urodynamic Procedures

   Urodynamic procedures will be reimbursed, subject to the multiple surgery reduction (MSR) policy at 100 percent (100%) for the primary procedure and 50 percent (50%) for each subsequent procedure when performed during the same session.

5. Procedure Code Modifier Reimbursement

   - Modifier 26 – Professional Component: Radiology procedures submitted by a physician with a facility place of service billed without modifier 26 will be denied. For example: Procedure code 71020 submitted by a physician in a facility place of service will be denied if submitted without modifier 26.
   - Modifier 47 - Anesthesia by Surgeon: Regional or general anesthesia services provided by the operating surgeon for a procedure will be included in the reimbursement for the surgical procedure and will not be eligible for separate reimbursement.
   - Reimbursement for eligible procedure codes submitted with modifier 62 (co-surgeon) will be allowed at 63% of the applicable fee schedule amount.
   - Reimbursement for eligible procedure codes submitted with modifier 63 (procedure performed on infants < 4 kg) will be allowed at 120% of the applicable fee schedule amount.
   - Reimbursement for eligible procedure codes submitted with modifier 78 (unplanned return to operating room for a related procedure) will be allowed at 70% of the applicable fee schedule amount.
   - Reimbursement for eligible procedure codes submitted with modifier 80 (assistant surgeon) will be allowed at 16% of the applicable fee schedule amount.
   - Reimbursement for eligible procedure codes submitted with modifier 81 (minimum assistant surgeon) will be allowed at 16% of the applicable fee schedule amount.
   - Reimbursement for eligible procedure codes submitted with modifier 82 (assistant surgeon – qualified resident surgeon not available) will be allowed at 16% of the applicable fee schedule amount.
   - Reimbursement for eligible procedure codes submitted with modifier AS (physician assistant, nurse practitioner or clinical nurse specialist services for assistant at surgery) will be allowed at 16% of the applicable mid-level provider fee schedule amount or at 14% of the applicable physician fee schedule amount.

   Note: Multiple surgical procedures performed on the same day will continue to be subject to the existing multiple surgery reimbursement methodology.

6. We will automatically update ClaimsXten to incorporate any CPT or HCPCS coding changes. This includes changes due to the addition of new codes as well as replacements for or revisions to existing codes. This update to ClaimsXten will incorporate the following coding changes:

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- CPT procedure codes 96360-96379 (Hydration and Therapeutic, Prophylactic and Diagnostic Injections and Infusions) billed by a physician with a facility place of service will be denied.

- CPT procedure codes 96401-96402, 96409-96425, 96521-96523 (Chemotherapy) billed by a physician with a facility place of service will be denied.

- CPT procedure codes 90281-90399 billed by a physician without base procedure code will no longer deny, cpt codes will be processed as submitted.

On July 19, 2009, our web-based tool – Clear Claim Connection - will be updated to incorporate the editing rules outlined above. This will allow you to view the clinical rationale for these changes when you enter claim scenarios. Clear Claim Connection may be accessed from our web site bcbsga.com. Please note that a user ID and password are required to access this application.

If you have questions concerning ClaimsXten, our reimbursement policies or this correspondence, please contact your provider representative. We appreciate your participation in our networks and look forward to continuing to work with you.

Sincerely,

Amy M. Cheslock
Vice President, Health Services

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