Arkansas Blue Cross and Blue Shield

Providers' News

June 2005

Inside the June Issue:

Arkansas State and Public School Employees Preventive Benefits	16-17
Claims Payment Issues & 1099 Earnings	9-11
Colonoscopy Guidelines	24-35
Coverage Policy Update	8
Evaluation & Management Billing by Radiologist	12-14
Home Health Agency Claims Filing	11
Incorrect Address — Do Not Use P O Box 1416	18
Internal Disc Decompression Therapy (IDD)	14
Maternity Benefits	5
Members Can Now Compare Hospital Measures Through *My BluePrint*	3
Modifier 59 Billing Instructions	20-24
National Drug Codes (NDC) on Claims	8
National Provider Identifier (NPI)	2
Out of the Scope of Practice of the Provider	7
PET Scan Code Changes	19
Proof of Timely Filing	15
Provider Service Number and My BlueLine	4
Sending Medical Records	7
Unsolicited Medical Records	6
What Customer Service Needs, to Help You...	15

Please Note:

Providers' News contains information pertaining to Arkansas Blue Cross and Blue Shield, a mutual insurance company, its wholly owned subsidiaries, and affiliates. The newsletter does not pertain to Medicare. Medicare policies are outlined in the Medicare Providers' News bulletins. If you have any questions, please feel free to call (501) 378-2307 or (800) 827-4814.

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www.ArkansasBlueCross.com
www.HealthAdvantage-hmo.com
www.BlueAdvantageArkansas.com
and www.fepblue.org

The Providers' News
The Providers' News is a quarterly publication of Arkansas Blue Cross and Blue Shield. Please send your questions or comments about the Providers' News to:

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National Provider Identifier (NPI):

On January 23, 2004, the U.S. Department of Health and Human Services published the final rule defining the National Provider Identifier (NPI) as the standard unique health identifier for health care providers. This rule stems from the requirements of Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The NPI is all numeric and is 10 positions in length. There is no embedded intelligence in the NPI with respect to the health care provider it identifies.

The NPI replaces legacy provider numbers (i.e. Blue Cross and Blue Shield numbers, Medicare numbers, Medicaid numbers, other commercial insurance companies' numbers, etc.). The NPI will be required on all standard electronic transactions. Insurance companies can also require the NPI on all paper claims.

The Centers for Medicare & Medicaid Services (CMS) contracted with Fox Systems to operate the National Plan and Provider Enumeration System (NPPES) and providers were able to begin applying to the NPPES to obtain an NPI on May 23, 2005 (https://nppes.cms.hhs.gov).

Beginning May 23, 2007, most commercial insurance carriers, health plans, Medicare, Medicaid, and healthcare clearinghouses must accept and use the NPI in all standard transactions. Small health plans will have until May 23, 2008 to begin accepting the NPI.

After the compliance dates, health care providers must use only their NPI to identify themselves in standard transactions, where the NPI is requested. If a provider, health plan or clearinghouse is out of compliance, it will be considered a federal offense.

Through May 2007, the date when CMS and HIPAA will only allow using the NPI, Arkansas Blue Cross and Blue Shield and its affiliate companies will continue to assign and utilize proprietary provider numbers during the NPI transition. In early 2006, Arkansas Blue Cross and Blue Shield will begin soliciting the NPI from our providers to facilitate population of our provider databases.

Arkansas Blue Cross will begin accepting the NPI from providers on standard transactions in mid-2006 and will officially notify providers on the specific effective date. Arkansas Blue Cross will likely need both the NPI and the current proprietary five-digit Arkansas Blue Cross provider number on standard transactions through May 2007.

After May 2007, Arkansas Blue Cross by law will not accept electronic claims transactions without an NPI. Electronic transactions, which HIPAA mandates in the ANSI 4010-A1 format, already contain specifications for including the NPI in the appropriate locations.

Please begin talking with practice management system vendors or claims staff to ensure proper population of the ANSI 837 claim NPI locations. Depending on revisions of the UB and CMS 1500 paper claims forms, Arkansas Blue Cross will likely require paper submitters to obtain and utilize an NPI.

Please visit the following websites for further information:

- www.cms.hhs.gov/hipaa/hipaa2 - for more information regarding the NPI,
- www.nubc.org - for additional information regarding the proposed revisions of the UB04 claim form, and
- Www.nucc.org - for additional information on the proposed revisions of the CMS 1500 claim form.

Members Can Now Compare Hospital Measures Through My BluePrint:

Members of Arkansas Blue Cross and Blue Shield, Health Advantage, and BlueAdvantage Administrators of Arkansas will be provided with a new tool to help them play a more active and informed role when a physician recommends surgery or another procedure that requires hospital care. This new tool, "Select Quality Care," allows members to receive an independent comparison of hospitals in their area by procedure or diagnosis.

Hospital Choice:

Select Quality Care will provide members with access to information--number of patients treated, mortality rate, number of complications and length of stay--that members can discuss with their physicians when making their choice.

Quality Measures:

Select Quality Care ranks hospitals on four measures, taking into account the importance members place on each measure.

1. Number of Patients Treated: Refers to the number of patients treated for a specific condition or procedure. Only hospitals that have treated more than 10 patients in a 12 month period for the specified diagnosis or procedure are included in the selection. If members navigate the site only to find no hospital near them meeting the 10-patient requirement to be ranked, it in no way implies poor quality.
2. Mortality Rate: The percentage of patients who died while being treated for a specific condition or procedure.
3. Complication Rate: The percentage of patients who developed problems while being treated.
4. Length of stay: The average number of days people stayed in the hospital for treatment of the specific condition or procedure.

Quality Data Source:

Select Quality Care provides information on all hospitals in Arkansas, both in-network and out-of-network, using public Medicare data. Members are asked to confirm with Customer Service or search the online provider directory to ensure the selected hospital is within their covered network.

How Members Use Select Quality Care:

To use the new hospital quality comparison tool, members can visit the Arkansas Blue Cross, BlueAdvantage, or Health Advantage websites and click on the My Blueprint link on the home page. Members will then log into the secured member portal before receiving access.

Select Quality Care is provided as a value-added service of the member's health plan at no additional cost and is available 24 hours a day, seven days a week to Arkansas Blue Cross, Health Advantage, and BlueAdvantage, members.

Provider Service Number and My BlueLine:

Arkansas Blue Cross and Blue Shield is happy to announce effective May 1, 2005 participating providers can now call My BlueLine at 1-800-827-4814 or 501-378-2307 for eligibility, claim status, and benefit information for members of Arkansas Blue Cross and Blue Shield, Health Advantage, and BlueAdvantage Administrators of Arkansas.

Note: Please continue using the existing telephone numbers for the following:

- Blue Card 1-800-880-0918
- Federal Employees Program (FEP) 501-378-2531 or 1-800-482-6655

Arkansas Blue Cross believes this will be a great enhancement for providers. Providers will no longer have to call multiple phone lines to get information on a member, depending upon whether the member's coverage is with Arkansas Blue Cross, BlueAdvantage, Health Advantage, or Medi-Pak .

If at any point a caller needs to speak with a Customer Service Representative during regular business hours, simply say "Customer Service." At that time, the caller will be given an option of visiting with a Customer Service Representative with Arkansas Blue Cross, Health Advantage, or BlueAdvantage.

Please note that for BlueAdvantage, there are several phone lines handling self-insured employer groups. Therefore, it may become necessary to direct callers to a phone number on the member's ID card.

Also, Arkansas Blue Cross has streamlined the flow of calls once in the self-service interactive voice response system (My BlueLine). Callers will find easier access to get the important information on eligibility and claim status.

Arkansas Blue Cross truly hopes that this self-service option is utilized as much as possible for routine questions and status updates. This will keep Customer Service Representatives available for any questions that cannot be answered through the self-service My BlueLine.

Arkansas Blue Cross also wants to remind providers that the same information is available through AHIN with additional detail for member eligibility, member benefits, claim status, and information on BlueCard for out-of-state Blue Plan coverage.

Note: This information and any benefit information provided is not a guarantee of payment or coverage and is only valid if all coverage criteria is verified when Arkansas Blue Cross receives the claim. Coverage criteria to be verified includes, but is not limited to, payment of premium, employment status under group plans, and dependent eligibility. No payment will be made for any services in connection with which there has been any negligent or intentional misrepresentation, or failure of disclosure, of any fact relevant to an eligibility or coverage determination.

Maternity Benefits:

Maternity benefits are determined by contract language and are paid accordingly. The following laboratory procedures are considered standard studies when performed during the course of pregnancy and are not included in the codes for prenatal care:

- Hemoglobin or CBC (85014, 85022-85027) performed in the first and third trimester;
- ABO/Rh (D) (86900/86901);
- Rh (D) antibody screen (86850);
- VDRL/RPR (86592);
- Hepatitis B Surface Antigen (HbsAg) (87340);
- Gonorrhea culture (87072);
- Chlamydial culture (82110);
- Urine culture ((87086);
- Antibody: Rubella / Rubeola / Varicella (86762 / 86765 / 86787);
- HIV (86701);
- Coombs (86886);
- Gestational diabetes mellitus screening (82950 or 82951);
- Group B streptococcal testing at 35-37 weeks gestation (87071 for swabs or 87798 for testing with the IDI-Strep B™ assay);
- Triple screen (AFP / HCG / Estriol) (82105 / 84702 / 82677).

Obstetric panel (80055) may be billed when all of the tests specified in the panel description are performed and when the code is used instead of billing individual tests.

Other laboratory studies during pregnancy are not considered routine and would be covered based on member benefit contract primary coverage criteria. This would be indicated on the claim by the use of an ICD-9 code that would support the performance of the test.

Depending on the member's benefit contract, a single routine obstetrical ultrasound may be covered (individual contracts prior to July 2004 may not have any coverage for routine obstetrical ultrasound imaging).

Examples of conditions which qualify for obstetrical ultrasound imaging include:

- Ultrasound in diagnosing abnormal pregnancy, eg.
  - Suspected ectopic pregnancy;
  - Suspected hydatidiform mole;
  - Threatened or missed abortion;
  - Congenital malformation, fetal or maternal;
  - Polyhydramnios/oligohydramnios;
  - Placenta previa;
  - Abruptio placenta;
  - Vaginal bleeding;
- Ultrasound for diagnosing other conditions affecting the fetus and/or delivery, eg.
  - Suspected abnormal presentation;
  - Suspected multiple gestation;
  - Significant discrepancy between uterine size and dates;
  - Elevated maternal serum alpha-fetoprotein;
  - Suspected fetal death;
  - Suspected anatomical uterine abnormality;
- Maternal risk factors such as family history of congenital anomalies, chronic systemic disease (eg, hypertension, diabetes, sickle cell disease), or substance abuse;
- Suspected fetal growth abnormality, either growth retardation or macrosomia;
- Determination of gestation for uncertain dates.

These conditions would generally be indicated by the use of an ICD-9 code from the range V230-V239 or 6400 to 6489. The interpretation of any obstetrical ultrasound code must include descriptions of all elements specified in the code description.

Unsolicited Medical Records:

Occasionally Arkansas Blue Cross and Blue Shield receives medical records that have not been properly mailed or faxed with the bar-coded cover sheet or are not sent to any individual's attention. In some cases, records are submitted with claims, other times only medical records are sent.

Effective immediately, Arkansas Blue Cross will begin returning all unsolicited medical records back to the provider's office. Arkansas Blue Cross is unable to determine who requested the medical records and for what purpose.

In the past, Arkansas Blue Cross has kept the unsolicited medical records on file. However in most cases, when a provider's office calls regarding the status of an associated claim, the corresponding medical records can not be located in the large file of unsolicited medical records. Since Arkansas Blue Cross telephone representatives have no record of receipt and the medical records were sent, providers become frustrated.

Please do not send medical records until requested. It is almost impossible to locate medical records not submitted appropriately. Please fax or mail the medical records using the bar-coded sheet as the cover page.

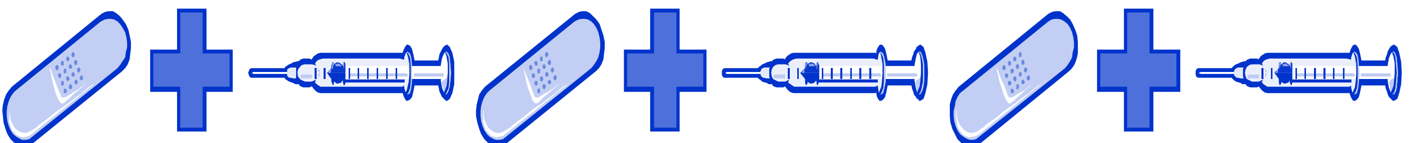
If there is a specific reason to send medical records not formally requested, please be sure to send the records to the attention of a specific person or area.

Located on the following page is information useful when it is necessary to submit medical records to Arkansas Blue Cross and Blue Shield (Except for FEP). Please consider posting the

helpful information in a convenient location to remind staff responsible for sending medical records. Consistently following these guidelines will result in a much more effective and efficient outcome to the benefit of both our organizations.

It is the goal of Arkansas Blue Cross to provide the most effective and efficient administration of claims submission in the industry. With the assistance of our providers, Arkansas Blue Cross will reach that goal and assure that our provider's claims and requests are processed in the most efficient manner.

Note: FEP has not implemented the process for requesting medical records using the bar coded sheet. Therefore when medical records are required for FEP, providers will continue to receive an FEP denial code on their Remittance Advice requesting the additional information. The requested medical records should be returned to FEP with a copy of the Remittance Advice.



Sending Medical Records:

If Arkansas Blue Cross and Blue Shield has requested medical records, or if there is a need to submit medical records for a specific purpose, please use the following guidelines:

1. When Arkansas Blue Cross requests medical records, the claim will be processed faster if the bar-coded sheet is faxed as the cover page with the requested medical records. The appropriate number for faxing medical records is 501-399-3926. Alternatively, mail the medical records using the bar-coded sheet as the cover page to:

   Arkansas Blue Cross and Blue Shield
   P.O. Box 3688
   Little Rock, AR 72203

   Note: Federal Employee Program (FEP) has not implemented the process for requesting medical records using the bar coded sheet. Therefore when medical records are required for FEP claims, providers will continue to receive an FEP denial code on their Remittance Advice requesting the additional information. The requested medical records should be returned to FEP with a copy of the Remittance Advice.

2. When requesting Arkansas Blue Cross review a claim that has been denied in whole or in part, please attach a cover letter specifically explaining the request and clearly mark the envelope "Claim Re-Review" and mail to:

   Arkansas Blue Cross and Blue Shield
   P.O. Box 2181
   Little Rock, AR 72203

   Does not apply to FEP. Please continue to send claims for Re-review to the attention of FEP customer service.

3. When requesting prior approval for coverage of a service, please send the supporting medical information with a letter specifically explaining the request to:

   Arkansas Blue Cross and Blue Shield
   Attn: Prior Authorization
   / MARS Division
   P.O. Box 3688
   Little Rock, AR 72203

   All medical records must include the patients' complete name and insurance Identification Number.

"Out of the Scope of Practice of the Provider":

Charges that are denied for "out of the scope of practice of the provider" are considered a write-off for the provider and the member cannot be billed.

If you have questions concerning procedures performed that could be considered "out of the scope of practice of the provider", please contact the regional Network Development Representative in your area.

Coverage Policy Update:

Since March 2005, the following policies have been added or revised in the Arkansas Blue Cross and Blue Shield Medical Policy Coverage Manual:

- Genetic Testing - Alzheimer's Disease;
- Genetic Testing - Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis in Patients with Breast Cancer;
- Omega-3 Fatty Acids in Red Blood Cell Membranes as a Cardiac Risk Factor;
- Clofarabine (Clolar™);
- Esophageal pH Monitoring;
- Hyperbaric Oxygen Pressurization (HBO);
- Insulin Potentiation Therapy;
- Kyphoplasty, Percutaneous;
- Prolotherapy (Sclerotherapy);
- Spinal Decompression Therapeutic Table (VAX-D, DRS);
- Transesophageal Endoscopic Therapy for GERD: Polymer Injections;
- Vertebroplasty, Percutaneous Polymethylmethacrylate;
- Abarelix (Plenaxis™);
- Bone Mineral Density Study;
- Low Osmolar Contrast Media (LOCM);
- Magnetic Resonance Imaging, Cardiac Applications;
- PET Scan, Positron Emission Tomography for Cervical Cancer;
- PET Scan, Positron Emission Tomography for Ovarian Cancer;
- Recombinant Human Thyrotropin for Radioactive Thyroid Scanning in Patients with Thyroid Carcinoma;
- Artificial Vertebral Disc;
- Chemodenervation (Botulinum Toxin);
- Electrical Deep Brain Stimulation, Thalamus for Tremor;
- Intraoperative Neurophysiologic Monitoring;
- HDC & Allogeneic or Autologous Hematopoietic Stem Cell Support for Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma;
- Virtual Colonoscopy / CT Colonography;
- Gastric Electrical Stimulation;
- Computer-aided Detection in Conjunction with Digitized Screen-film Mammography or Full-Field Digital Mammography;
- Small Low Density Lipoprotein (LDL) Particles Measurement; and
- HDC & Autologous &/or Progenitor Cell Support-Primary Amyloidosis;

The Coverage Policy manual is available on both the Member and Provider pages of the Arkansas Blue Cross, BlueAdvantage, and the Health Advantage websites.

National Drug Codes (NDC) on Claims:

When filing electronic claims that contain National Drug Codes (NDC) to Arkansas Blue Cross and Blue Shield, Health Advantage, and BlueAdvantage Administrators, do not include any special characters in the NDC number.

Effective May 1, 2005, electronic claims with NDC numbers that contain dashes or any other special characters will be rejected and must be corrected and re-filed.

Claims Payment Issues and 1099 Earnings:

While one of Arkansas Blue Cross and Blue Shield's ongoing goals is to minimize the number of claims paid incorrectly, errors will occasionally be made. Some of these error conditions can affect 1099 earnings and/or patients' claim history, deductibles, and benefit limits. These situations can result in incorrect information being reported to the IRS and/or incorrect patient benefit determination.

Please note:

- Amounts of issued provider payee checks are recorded as increases to the 1099 earnings;
- Amounts of voided provider payee checks are recorded as decreases to the 1099 earnings;
- Amounts received from providers (claims refunds) are recorded as decreases to the 1099 earnings.
- 1099 earnings are accumulated under the Tax Identification Number (TIN) of the payee, as recorded in Arkansas Blue Cross files at the time of the transaction.
- Providers must notify Arkansas Blue Cross promptly if their TIN or name changes in order to ensure accurate reporting to the IRS. If the IRS sends Arkansas Blue Cross a "B-Notice" indicating that the Taxpayer Name and TIN filed does not match the IRS records, Arkansas Blue Cross will be required to withhold, and remit to the IRS, 28% of future amounts payable to the provider if corrected data is not received within the mandated time frame. Once withheld amounts are remitted to the IRS, they cannot be refunded to a provider, but will be reported on the provider's 1099 as Federal Income Tax Withheld.

Important Claims Filing Notes to Physicians:

- Paper Claims: As the provider of service, always enter the individual provider number in box # 24K of the CMS1500 claim form. If a clinic is the payee, enter the clinic's provider number in box # 33.
- NSF Electronic Claims: As the provider of service, always enter the individual provider number beginning in position 93 of field 23 on the FA0 record.
- Non-Medicare claims: Providers must enter the "pay to" provider number beginning in position 105 of field 14 on the BA0 record for non-Medicare claims.
- Medicare claims: The "pay to" provider number must be entered beginning in position 48 of field 9 on the BA0 record for Medicare claims.
- For ANSI 837, Version 4010A1 Electronic Claims: Please refer to the ANSI X12N 837 Implementation Guide for instructions regarding the use of Loop 2010AA, REF02 or Loop 2010AB, REF02 for the "pay to" provider and Loop 2310B, REF02 or Loop 2420A, REF02 for the rendering provider number.
- Deductibles, out-of-pocket maximums, benefit limits, and lifetime maximums are accumulated by individual member. If erroneous claims are not adjusted appropriately and promptly, subsequent claims may be incorrectly adjudicated.
- Please verify that the payee is correct on all checks received prior to negotiating them.

Listed below are examples of some situations that can occur along with procedures recommended to facilitate correction of the data.

- Receive payment for a claim for services not provided: Please refund the amount paid in error. Even if a provider knows to whom the payment should have been made, do not forward the amount to that party. A 1099 can only be corrected if the money is returned so that the claim can be

(Continued on page 10)

(Continued from page 9)

re-processed to the appropriate party.

- Patient was paid and payment should have been made directly to a provider: Please advise the patient to return the check, or refund the amount paid, along with a request to re-process the payment to the provider. If a provider accepts payment from the patient, Arkansas Blue Cross could subsequently discover the error and send a request for refund to the patient since records will reflect that they received the payment.
- Provider received payment and payment should have been made to the patient: Please refund the payment to Arkansas Blue Cross (rather than to the patient) along with a request to re-process the payment to the patient. A provider's 1099 can only be corrected if the money is returned, so that the claim can be re-processed to the appropriate party.
- Check is made payable to an individual physician but should have been made payable to the clinic: Please return the check to Arkansas Blue Cross (rather than depositing it in the clinic's account) with a request to re-process the payment to the appropriate provider. A provider's 1099 can only be corrected if the money is returned, so that the claim can be re-processed to the appropriate party. NOTE: If the check is made payable to an individual physician, the 1099 will be generated in the physician's name, even if they are employees of the clinic.

Arkansas Blue Cross recommends providers endorse and deposit all checks as soon as possible after confirming that the payee is correct. Most checks have a pre-printed stale date message indicating that the check will be void if not cashed within a specific time frame (usually six months). After that time, the check must be re-issued or, in some cases, the claim must be re-processed.

As a deterrent to fraud and to enhance the quality of copies of cleared checks that might be requested in the future, Arkansas Blue Cross also recommends that endorsements be made in black ink and include the bank account number into which the deposit is being made.

To minimize the time required to process a claim refund and to ensure that a provider's 1099 earnings are adjusted accurately, review the following information:

- When sending a requested refund: Please return the remittance copy of the refund request letter along with the check.
- When sending an unrequested refund: It is not necessary to return the original check and the entire remittance advice/ explanation of payment if just one or two patient claims are paid incorrectly. Please enclose copies of the remittance advice/ explanation of payment pages with the claims paid in error highlighted and a notation of the reason for the refund or enclose the following information for each claim paid in error:
  (1) Reason for the refund,
  (2) Patient name,
  (3) Patient ID number,
  (4) Date of service,
  (5) Amount
  (6) Provider name (pay to)
  (7) Provider number (pay to), and
  (8) TIN (pay to).

If a provider is not returning the original check, a separate refund check for each claim is preferred. A provider's 1099 earnings can only be corrected if Arkansas Blue Cross has the specific provider name, number, and TIN. If a provider uses the services of a third party for these financial transactions, please instruct the third party administrator to provide this information on each refund.

(Continued from page 10)

Please do not combine refunds for Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, Health Advantage, USAble Administrators, or Medicare. Please do not issue refund checks to Arkansas First Source. The check should be payable to the original claim payer with a copy of the remittance advice/explanation of payment.

Note: Federal Employee Program (patient ID# begins with "R") refunds should not be combined with others to Arkansas Blue Cross and Blue Shield in order to comply with new timeliness standards even though the refunds are sent to the same processing location.

The following are the correct addresses to use for claims refund:

Arkansas Blue Cross Blue Shield
P.O. Box 2099
Little Rock, AR 72203-2099

ABCBS/Federal Employee Program
P.O. Box 2099
Little Rock, AR 72203-2099

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, AR 72203-1460

Health Advantage
P.O. Box 8069
Little Rock, AR 72203-8069

USAble Administrators
P.O. Box 1460
Little Rock, AR 72203-1460

Medicare (part A or B)
P.O. Box 8075
Little Rock, AR 72203-8075

Home Health Agency Claims Filing:

Effective June 1, 2005, Home Health Agencies will no longer need to attach medical records or nurse notes to their claims when filing claims with Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, Health Advantage, and the Federal Employee Program (FEP).

If additional records are needed, Home Health Agencies will receive a faxed record request except from FEP. Please ensure fax numbers have been updated in the Arkansas Blue Cross provider databases. To make changes to fax numbers, please use the interactive change forms located under the provider section of the Arkansas Blue Cross and Blue Shield web site at www.ArkansasBlueCross.com.

As a result of not always requiring records to be attached to claims, Home Health Agencies are now able to file claims electronically.

Note: FEP has not implemented the process for requesting medical records using the bar coded sheet. Therefore when medical records are required for FEP, providers will continue to receive an FEP denial code on their Remittance Advice requesting the additional medical records information. The requested medical records should be returned to FEP with a copy of the Remittance Advice.

Evaluation and Management Billings by a Radiologist:

The radiology section of the 2005 Current Procedural Terminology (CPT) guidelines includes codes for:

1) The technical and interpretive components of diagnostic plain film, CT, CTA, MRI, MRA, PET, fluoroscopic and ultrasound procedures;
2) The interpretation of plain film, CT, CTA, MRI, MRA, fluoroscopic and ultrasound procedures performed during guidance of interventional procedures, and designated as supervision and interpretation (S&I) services; and
3) Various radiation oncology procedures.

Items (1) and (2) are considered in this payment policy. Payment for Evaluation and Management (E&M) services performed at the same time as various radiation oncology procedures are adjudicated based on other CPT code guidelines.

Payment for radiological procedures (total, technical, or professional component), not identified in CPT guidelines as a Supervision and Interpretation service (S&I), includes the work of explanation of the procedure, etc., to the patient, and any discussion with the patient or the attending physician(s) following the procedure.

Radiological procedures, done during an interventional procedure, are reported separately from the interventional procedure. These radiological procedures are identified by the phrase "Supervision and Interpretation" and are known as "S&I" codes. The interventional procedure may be done by two physicians, often of different specialties. One physician may report the interventional procedure, while the second physician reports the S&I service. The same physician, however, may report both the interventional and S&I procedure. E&M services performed on the same day as an S&I procedure are covered under specific conditions.

The following information is included in the American College of Cardiology's Interventional Radiology Coding User's Guide:

> "Evaluation and Management services (E&M) are considered separately from Supervision and Interpretation (S&I) codes and may be used if E&M is provided and according to the conventions established concerned with the globality of the particular procedural service in question. In short, brief review of history and physical exam and obtaining informed consent is not a separately reportable E&M service."
>
> "However, consultations, full or directed patient history and physical examination, outpatient and/or inpatient visits (new or established patient) are separately reportable and payable services…"
>
> "Furthermore, certain pre and post procedural care is included in the global periods for minor and major surgery is included in the global periods for minor and major surgery and 'scopy' services…"
>
> "Evaluation and management services performed on the same date of service as a minor surgery or –scopy are not separately paid. This is based on the assumption that most patients are already established patients when they appear for their minor surgical or –scopy procedure. Therefore, the preoperative evaluation would most likely have been performed and separately paid on a preceding date of service. If this is not the case and the patient is presenting

for the first time and only receives E&M which is directed to ensure a safe minor surgery or –scopy, this would both be separately reported and paid. However, if the patient is being seen for the first time and receives an extensive evaluation and management service, this should be reported with the Modifier 25 for a separate and significant evaluation and management service on the date of a procedure…"

"Modifier 24: This code may have utility if a provider is called upon to provide an E&M service for a new problem during the post-operative period of a service previously performed. An example might be the E&M of an ischemic leg in a patient in whom the provider had previously drained a hepatic abscess. The E&M service should have Modifier 24 added to that code since the E&M services inherent in the abscess drainage would not be separately billable during the 90-day postoperative period for the abscess drainage."

"Modifier 25: This has been previously discussed in the introduction to these codes. This modifier may have utility when a full evaluation and management service is performed on the same date of services as a minor surgery or –scopy."

Plain film, CT, CTA, MRI, MRA, PET, or Ultrasound procedure not identified as an S&I code by CPT guidelines:

An RVU for work, practice expense, and malpractice expense for E&M services by a radiologist, performed on the same day as a diagnostic plain film, CT, CTA, MRI, MRA, PET or ultrasound procedure are included in the work, practice expense, and malpractice expense of the CPT code for the radiological procedure. Hence, an E&M service, if billed by a radiologist (specialty 30, 36, 92, or 94) on the same day as any of these codes, would be denied as a fragmentation of the radiology service.

Radiological S&I codes designated for interventional procedures with a 90-day global period:

Payment for E&M services by a radiologist, reported on the same day by the same radiologist who reports an S&I CPT code designated for an interventional procedure with a 90-day global is allowed if:

1) The radiologist also performs and reports the interventional procedure for which there is a designated S&I code;
2) The Evaluation and Management service has Modifier 24 appended; and
3) All necessary components of the E&M service are provided (chief complaint, history, physical, and decision making).

The work, practice expense, and malpractice expense for the brief review of the history and physical, explanation of the description and risks of the procedure, and/or obtaining informed consent for the procedure are included in the allowance for the interventional procedure and S&I service, and additional payment for E&M is not allowed if only these services are performed (American College of Radiology Interventional Radiology User's Guide coding instructions). It is assumed that E&M services are medically necessary when the patient is undergoing an interventional procedure associated with a 90-day global, and no supporting information is required with the claim; however, records may be audited to determine if all necessary components of the E&M service were provided.

Radiology Supervision and Interpretation (S&I) codes designated for interventional procedures with a 0-day or 10-day global period:

Payment for Evaluation and Management services by a radiologist, reported on the same day by the same radiologist who reports an S&I code designated for an interventional procedure with a 0-day or 10-day global period is allowed if:

(Continued on page 14)

(Continued from page 13)

1) The radiologist also performs and reports the interventional procedure for which there is a designated S&I code;
2) The Evaluation and Management service provided is for a separately identifiable medical condition;
3) The Evaluation and Management service has Modifier 25 appended; and
4) All necessary components of the Evaluation and Management service are provided (chief complaint, history, physical, and decision making).

The work, practice expense, and malpractice expense for brief review of the history and physical, explanation of the description and risks of the procedure, and/or obtaining informed consent for the procedure are included in the allowance for the interventional procedure and S&I service, and additional payment for E&M is not allowed if only these services are performed (American College of Radiology Interventional Radiology User's Guide coding instructions).

Records for Evaluation and Management service reported on the same day as interventional procedures with 0-day and 90-day global procedures may be requested prior to payment to determine if the Evaluation and Management service was for a separately identifiable condition; and records may be audited post-procedure to determine if the requirements (2) and (4) above have been met.

Radiology S&I code billed by one radiologist and interventional procedure billed by second radiologist:

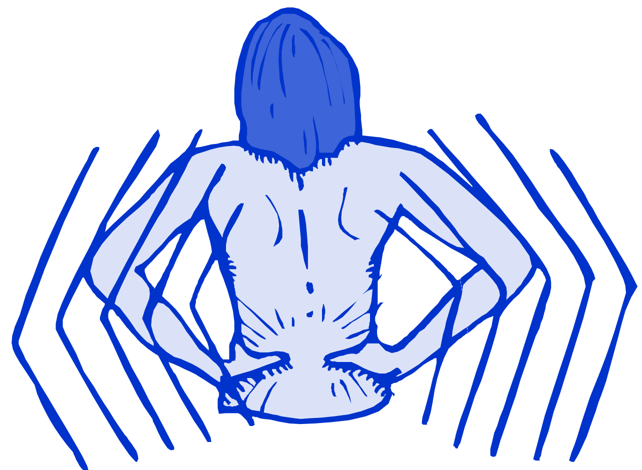
If one radiologist performs the interventional procedure, and a second radiologist performs the Supervision and Interpretation code, any appropriate Evaluation and Management service should be billed by the radiologist performing the interventional procedure, with adherence to the above guidelines.

Internal Disc Decompression Therapy (IDD):

Arkansas Blue Cross and Blue Shield does not cover Internal Disc Decompression (IDD) Therapy. Use of the spinal decompression therapeutic table for the treatment of low lack pain is not covered due to lack of medical data attesting to effectiveness and therefore does not meet member benefit contract Primary Coverage Criteria requirements for coverage.

To report Internal Disc Decompression (IDD) Therapy to Arkansas Blue Cross or its affiliates, use HCPCS code S9090.

Coverage Policy 1997233 for Spinal Decompression Therapeutic Table (IDD Therapy) is available on the Arkansas Blue Cross web site at www.ArkansasBlueCross.com. Coverage Policy can be found under both the Member and the Provider sections of the web site.



What Customer Service Needs, to Help You…

When a provider calls to verify benefits, please provide details regarding the services the member is receiving. For example, instead of asking for the Durable Medical Equipment (DME) benefit, please disclose the item the member is receiving.

Some DME items are not covered or may require prior approval. If a provider only asks a general benefit question, the customer service representative can only quote the general benefit. No service is guaranteed prior to the claim being submitted. However, if the item is not covered or if there is a guideline that must be followed, that information can be shared with the provider.

Other areas of concern but not limited to are:

- Outpatient procedures,
- Orthotics,
- Supplies, and
- Treatments that could be considered investigational.

Proof of Timely Filing:

Documents submitted as proof of timely filing will only be accepted if computer generated and contain the following information:

- Physician or Facility Name;
- Patient's name and member ID#;
- Date of service;
- Charged amount;
- CPT code;
- Date claim was originally filed/resubmitted;
- Insurance filed is listed as Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, or Health Advantage (Insurance codes are not acceptable unless a memo accompanies the print out describing the code.); and
- If the insurance filed shows a plan other than Arkansas Blue Cross, BlueAdvantage, or Health Advantage, a memo should be attached indicating when the provider was notified that the member had other insurance and any circumstances that caused the delay in filing with the correct or the delay in checking the status of the claim. These cases will be reviewed. If the member did not notify the provider of the correct insurance plan, the claim should not be filed and the member can be billed.

If a provider attached a claim correction form to the claim with proof of timely filing, this can expedite the process since the scanning system should halt the claim for review.

The following will not be accepted as proof of timely filing:

- Hand written notes indicating date the claim was filed;
- Computer notes with incomplete information;
- Insurance codes with no explanation;
- Proof of timely filing with a date of service past 180-days from the current date; (Extenuating circumstances may be reviewed by attaching a memo.)
- Dates on the bottom of the claim submitted as proof; or
- When Arkansas Blue Cross, BlueAdvantage, or Health Advantage is secondary, 180-day timely filing starts from the primary carrier's Remittance Advice date of payment or denial.

Arkansas State and Public School Employees Preventive Benefits:

Effective October 1, 2004 for Public School Employees and January 1, 2005 for Arkansas State Employees, certain preventive procedures are paid without deductible, coinsurance or copayments applied to the patient's liability. The following charts are an on-going update to the list of covered procedures.

Please note that due to Medicare claims filing regulations, several 'G' codes have been added to this list of covered procedures. These codes will be allowed when a claim is crossed-over from Medicare to Arkansas Blue Cross and Blue Shield or Health Advantage. If Blue Cross or Health Advantage is the primary insurance carrier, providers should not use the 'G' procedure codes.

Providers should call 1-800-482-8416 to verify benefits and check claims status for ASE/PSE members.

New Patient - Well Baby Visits:

CPT Codes	Ages	Diagnosis Code Required
99381	Under 1 year	Must be billed with diagnosis code V20.2

New Patient - Annual Preventive (Under 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99382	Age 1-4	Early Childhood--Must be billed with diagnosis code V20.2
99383	Age 5-11	Late Childhood--Must be billed with diagnosis code V20.2
99384	Age 12-17	Adolescent--Must be billed with diagnosis code V20.2

New Patient - Annual Preventive (Over 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99385	Age 18-39	Must be billed with diagnosis codes V72.3, V70, V70.0, V7231, V7232, or V7612.
99386	Age 40-64	
99387	Age 65+	

Established Patient - Well Baby Visits (Under 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99391	Under 1 Year	Must be billed with diagnosis code V20.2

Established Patient - Annual Preventive Care (Under 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99392	Age 1-4	Early Childhood--Must be billed with diagnosis code V20.2
99393	Age 5-11	Late Childhood--Must be billed with diagnosis code V20.2
99394	Age 12-17	Adolescent--Must be billed with diagnosis code V20.2

Established Patient - Annual Preventive Care (Over 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99395	Age 18-39	Must be billed with diagnosis codes V72.3, V70, V70.0, V7612, V7231, or V7232.
99396	Age 40-64	
99397	Age 65+	

Newborn Care -Well Baby Visits (Under 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99432	Under 1 Year	Must be billed with diagnosis code V20.2

Preventive Care—Adult (members age 18 and over):

Description	CPT Codes	Ages	Diagnosis Code Required
Annual Physical		Age 18+	Must be billed with diagnosis codes V72.3, V70, V70.0, V7612, V7231, or V7232.
Office Visit	99385 & 99395	Age 18-39	
Office Visit	99386 & 99396	Age 40-64	
Office Visit	99387 & 99397	Age 65 +	
Laboratory Services	81000-81005, 80051, 80053, 80061, 85018, 85014, 85025, or 85027	Age 18+	

- Screening Mammogram (including breast exam)

Description	CPT Codes	Ages	Diagnosis Code Required
Mammogram, unilateral	76090, 76091, 76092 and G0202, or Revenue Code 403	Age 40 +	Allowable with any diagnosis code.
- with computer-aided detection	76083	Age 40 +	

- Pap Smear

CPT Codes	Ages	Diagnosis Code Required
88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174-88175, G0101, Q0091	Age 18+	Allowable with any diagnosis code.

- Prostate Specific Antigen (PSA)

CPT Codes	Ages	Diagnosis Code Required
84152, 84153, 84154, G0102, G0103	Age 40 +	Allowable with any diag. code.

- Colorectal Cancer Screening (Choice of the following beginning at age 50)

Description	CPT Codes	Age /Frequency	Diagnosis Code Required
Fecal occult blood test and one of the following:	82270, 82274, G0107	Annually	Allowable with any diagnosis code.
- Flexible sigmoidoscopy	45330—45339, G0104	Every 5 years	
- Colonoscopy	45378—45385, G0105 or G0121	Once every 10 yrs	
- Double contrast barium enema	74280, G0106	Once every 5 yrs	

- Cholesterol and HDL Screening

Description	CPT Codes	Age / Frequency	Diagnosis Code Required
Males Age 35+	82465, 83718-83721	Once every 5 yrs	Allowable with any diagnosis code.
Females Age 45+	82465, 83718-83721	Once every 5 yrs	

Immunizations – Adult (members age 18 and over):

Description	CPT Codes	Age / Frequency	Diagnosis Code Required
Diphtheria	90719	Every 10 years	Allowable with any diagnosis code.
Diphtheria and Tetanus toxoid (Td) ages over seven	90718	Every 10 years	
Hepatitis B (Hep B)	90740, 90747, 90746	Once Per Lifetime	
Influenza	90658	Annually	
Pneumococcal Conjugate	90732	Adults over 55 or immunosuppressed	

Preventative Care—Child:

Description	CPT Codes	Age / Frequency	Diagnosis Code Required
All childhood immunizations		Under age 18	Allowable with any diag code.

Incorrect Address — Do Not Use P O Box 1416:

Arkansas Blue Cross and Blue Shield, Health Advantage, BlueAdvantage Administrators of Arkansas, and Medicare Services are asking for help to end a private citizen's continuing problem of receiving mail belonging to our companies.

An incorrect mailing address is being used by providers. Mail is being incorrectly addressed to P O Box 1416 which has been a mailing address for this citizen for many years. To date, this citizen has sent the misdirected mail to Arkansas Blue Cross which is commendable but causes delays in response time.

Each provider using the incorrect address has been contacted but the problem still continues. Please check your files and alert your billing vendors of the urgency to change the mailing information to the correct P O Box.

The goal of Arkansas Blue Cross is to eliminate any and all delays in timely response to our provider's concerns and in claims payments.

Please use the following mailing address when sending a correspondence:

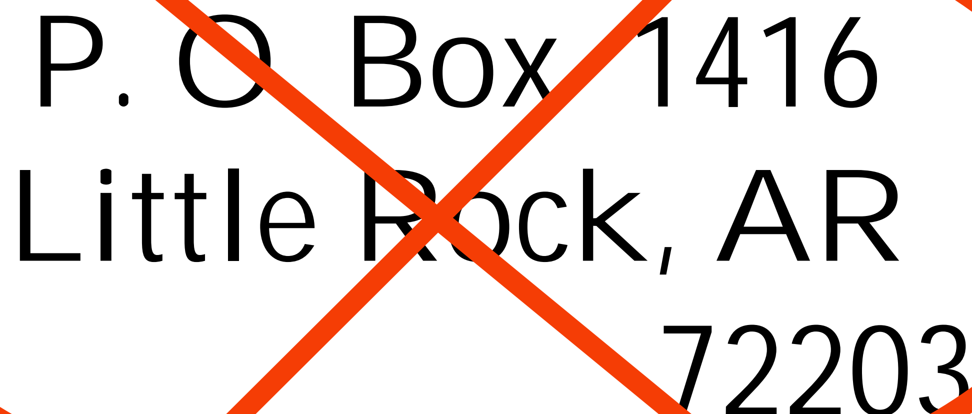
Arkansas Blue Cross Blue Shield
P.O. Box 2181
Little Rock, AR 72203-2181

Health Advantage
P.O. Box 8069
Little Rock, AR 72203-8069

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, AR 72203

Medicare Services
PO Box 1418
Little Rock, AR 72203

PLEASE DO NOT USE P.O. BOX 1416!



PET Scan Code Changes:

The March 2005 issue of the Providers' News introduced six new PET Scan CPT codes effective January 1, 2005. Providers were instructed to file an appropriate/corresponding "G" code in the range of G0210 through G0336.

An update to the HCPCS code set has been issued by Centers for Medicare & Medicaid Services (CMS) that terminates the use of codes G0210—G0336 effective April 1, 2005. Therefore, effective immediately, any service billed with codes G0210 – G0336 will be denied/rejected.

The following six new PET Scan CPT codes were effective January 1, 2005, replacing CPT code 78810:

New 2005 PET Scan CPT Codes added 01/01/2005	Description
78811	Tumor imaging, positron emission tomography (PET); limited area (eg, chest, head/neck)
78812	Tumor imaging, positron emission tomography (PET); skull base to mid-thigh
78813	Tumor imaging, positron emission tomography (PET); whole body
78814	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (eg, chest, head/neck)
78815	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid-thigh
78816	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body

Please disregard the previous instructions printed in the March 2005 issue of the Provider's News. Arkansas Blue Cross and Blue Shield WILL accept the above codes. CPT Codes 78814-78816 will NOT be denied effective July 1, 2005 as previously indicated.

If you have questions regarding this change, email: codespecificinquiry@arkbluecross.com.

Modifier 59 Billing Instructions:

Modifier 59 recognizes a distinct procedural service and is defined as:

"Under certain circumstances, the physician may need to indicate that a procedure was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than Modifier 59. Only if no more descriptive modifier is available, and the use of Modifier 59 best explains the circumstances, should Modifier 59 be used."

Arkansas Blue Cross and Blue Shield is seeing an inappropriate utilization of Modifier 59. Modifier 59 should never be used when only one procedure code is billed for the date of service, as Modifier 59 only applies to a second or separate procedures performed on the same day.

Modifier 59 is never appropriate for Evaluation and Management (E&M) codes. Modifier 25 is the appropriate modifier to bill when reported with an evaluation and management service on the same day as a procedure code with a 0, 10, or 90-day global to identify a separate and distinct E&M service. E&M services represent "daily services", and the Relative Value Units (RVU) for E&M services include some RVUs for the case in which the physician must see the patient more than once in a 24-hour day. In this case, the E&M code that best describes ALL the E&M services provided on that day should be reported.

As a general rule for surgical procedures, if a surgery would be reimbursed based on multiple surgery guidelines without Modifier 59, no additional reimbursement would be warranted with the Modifier 59 appended. Inappropriate appending of Modifier 59 will result in additional claim processing time and potential requests for clinical information. Most billings of Modifier 59 will require submission of medical records. The documentation in the medical record should clearly support the distinct and independent status of the procedure to which Modifier 59 has been appended.

American Medical Association Guidelines:

Modifier 59 was added in the 1997 edition of the Current Procedural Terminology (CPT) book. Modifier 59 is intended to clearly designate instances when distinct and separate multiple services are provided to a patient on a single date of service.

Not all multiple procedures performed at the same operative session are the same. They may be within the same incision, within the same field, and/or in different fields.

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures or services that are not normally reported together, but are appropriate under the circumstances. This may represent any of the following:

- Different session or patient encounter;
- Different procedure or surgery;
- Different site or organ system;
- Different incision or excision;
- Separate lesion; or
- Separate injury (or area of injury in

extensive injuries) not ordinarily encountered or performed on the same day by the same physician.

However, when another already established modifier is appropriate, it should be used rather than Modifier 59. Only if no more descriptive modifier is available, and the use of Modifier 59 best explains the circumstances, should Modifier 59 be used.

Separate Procedures:

Coinciding with the addition of CPT Modifier 59, some CPT codes were designated as "separate procedures." Some of the procedures or services listed in the CPT nomenclature that are commonly carried out as an integral component of a total service or procedure have been identified by including the term "separate procedure." The codes designated as separate procedures should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

However, it is important to consider that when a procedure or service designated as a "separate procedure" is carried out independently, or considered to be unrelated or distinct from other procedures or services provided at that time, it may be reported by itself or in addition to other procedures or services by appending the Modifier 59 to the specific separate procedure code. This indicates that the procedure is not considered a component of another procedure but is a distinct, independent procedure. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries.)

Examples of CPT codes with the term "separate procedure" in the code description are as follows:

- 29870 – Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure);
- 38780 – Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal notes (separate procedure);
- 44312 – Revision of ileostomy; simple (release of superficial scar) (separate procedure);
- 53230—Excision of urethral diverticulum (Separate procedure); female;
- 60520 – Thymectomy, partial or total; transcervical approach (separate procedure);
- 66625 – Iridectomy, with corneoscleral or corneal section; peripheral for glaucoma (separate procedure).

Examples:

<u>Example 1:– Surgery:</u>

A patient underwent placement of a flow-directed pulmonary artery catheter for hemodynamic monitoring via the subclavian vein (93503). Later in the day, the catheter had to be removed and a central venous catheter was inserted through the femoral vein.

CPT Code(s) Billed: 93503, 36010-59

- 93503 – Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes.
- 36010-59 – Introduction of catheter, superior or inferior vena cava.

Rationale for Using Modifier 59:

Because the pulmonary artery catheter requires passage through the vena cava, it may appear that the service for the catheter was being "unbundled" if both services are reported on the same day. Accordingly, the central venous catheter code should be reported with Modifier 59 (CPT code 36010-59), indicating that this catheter was placed in a different site as a different service on the same day.

<u>Example 2: Surgery:</u>

A patient who was complaining of right knee pain underwent an arthroscopic meniscectomy,

(Continued on page 22)

(Continued from page 21)

medial and lateral, with shaving of the articular cartilage.

CPT Code(s) Billed:

- 29880 — Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any mensical shaving).
- 29877 — Arthroscopy, knee, surgical, debridement/shaving of articular cartilage (chondroplasty).

Rationale for Not Using Modifier 59:

Since CPT code 29880 includes the meniscal shaving, Modifier 59 cannot be used to indicate that the procedures are separate and distinct. Modifier 59 should not be appended to CPT code 29877 and is "bundled" into CPT code 29880.

Laboratory Reporting With Modifier 59:

If multiple bacterial blood cultures are tested, including isolation and presumptive identification of isolates, then CPT code 87040, Culture, bacterial; blood, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate), should be used to identify each culture procedure performed. Modifier 59 should be appended to the additional procedures performed to identify each additional culture performed as a distinct service.

To assist users with the appropriate use of this series of codes, additional guidelines for use of Modifier 59 and Modifier 91 are given in the microbiology sub-section of the CPT book.

The microbiology guidelines state:

"Presumptive identification of microorganisms is defined as identification by colony morphology, growth on selective media, Gram stains, or up to three tests (eg, catalase, oxidase, indole, urease). Definitive identification of microorganisms is defined as an identification to the genus or species level that requires additional tests (eg, biochemical panels, slide cultures). If additional studies involve molecular probes, chromatography, or immunologic techniques, these should be separately coded in addition to definitive identification CPT codes (87140-87158). For multiple specimens/sites, use Modifier 59. For repeat laboratory tests performed on the same day, use Modifier 91."

Example 3: Laboratory and Pathology:

A 14-year old boy presented as an outpatient to the laboratory for aerobic and anaerobic culture of 2 sites of a single vertical wound to the anterior left foreleg, which was a result of a scooter mishap. The laboratory technologist obtained independent specimens, one from the proximal wound site and one from the distal wound site, for aerobic culture of the drainage material for testing, using the appropriate type of aerobic Culturette. The laboratory technologist also obtained independent specimens by means of anaerobic culturettes, one from the proximal wound site and one from the distal wound site, for anaerobic culture of the drainage material for testing.

CPT Codes Billed:

- 87071 — Culture, bacterial; quantitative, aerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool;
- 87071-59 — Culture, bacterial; quantitative, aerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool;
- 87073 — Culture, bacterial,- quantitative, anaerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool;
- 87073-59 — Culture, bacterial; quantitative, anaerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool;

Example 4: Medicine:

Pressure sores on a patient's right ankle and right hip were debrided in the morning but,

because of the patient's condition, selective debridement of a sacral pressure sore was performed at a separate session in the afternoon on that same date by the same provider.

CPT Codes Billed:

- 97601 — Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (eg, high pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, truction (s) for ongoing care, per session;
- 97601-59 — Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (eg, high pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, instruction(s) for ongoing care, per session;

Rationale for Using Modifier 59:
In this example, CPT codes 97601 and 97601-59 should be reported to identify procedures that are not normally reported together, but are appropriate under the circumstance, and represent a different session or patient encounter and different site. Since CPT code 97601 is per session and 2 sessions on the same day are medically necessary, it is appropriate to bill CPT code 97601-59 for the second session.

Review of Modifier 59:

1. Modifier 59 is used to report distinct and separate procedures performed on the same day.
2. Modifier 59 should be used with caution since this modifier affects the processing and reimbursement. This modifier is not designed to provide reimbursement for separate procedures that are performed as an integral part of another procedure. Use of the modifier will normally require submission of medical records.
3. When a procedure is described in the CPT code descriptor as a "separate procedure" but is carried out independently or is unrelated to other services performed at the same session, the CPT code may be reported with Modifier 59.
4. Modifier 59 should not be used when another, more descriptive modifier is available.
5. Documentation needs to be specific to the distinct procedure or service clearly identified in the medical record.

There are modifiers available that describe the body location. (i.e., LT and RT, for left and right side. There are others to describe specific digits, eyelids, etc.) If a modifier is available that specifically describes the body location, that modifier should be used INSTEAD of Modifier 59.

The September 2004 Providers' News provided information on Clear Claim Connection (CCC), a new tool available to our providers via the Advanced Health Information Network (AHIN) website. This tool should be used to determine the appropriate use of Modifier 59. The code combination being billed should be entered into CCC, without Modifier 59. If Modifier 51 applies to the secondary procedure, our reimbursement for covered services will be based on 50% of the allowance for the secondary procedure(s). We will not order records for these services. Providers may append Modifier 59 to these claims when warranted, but it may delay the processing of your claim.

If the secondary procedure would be denied based on CCC and it meets the conditions for billing, Modifier 59 should be appended AND Arkansas Blue Cross will require submission of records in MOST cases. When medical records are needed, they will be requested via our

(Continued on page 24)

(Continued from page 23)
automated Medical Records Request system.

If CCC combines two procedures into one procedure that includes both of the services provided, providers should bill for the one procedure that includes both procedures. For example, CPT codes 93501 and 93510 are more accurately reported using CPT code 93526.

Arkansas Blue Cross and Blue Shield receives in excess of 7,500 line items per month with Modifier 59 appended. Arkansas Blue Cross has reviewed numerous claims submitted with Modifier 59. Listed below are examples of inappropriate billing of modifier 59:

Modifier 59 is NEVER appropriate with:

- E&M codes (99200-99499);
- Anesthesia Procedures (00100-01999, 99100-99140);
- Single procedure on the date of service;
- Administration codes corresponding to injection, immunization or vaccine. The administration is paid separately from the code for the drug without addition of Modifier 59;
- Injection codes with multiple units. Providers are expected to bill for the appropriate dosage. If the injection code is for 50 mg, you give 100 mg, providers should bill with 2 units of service. Modifier 59 is not necessary.
- EVERY administration code on a claim;
- E&M, influenza vaccine and administration. This combination is acceptable without Modifier 25 on the E&M and/or without Modifier 59 on the administration code.
- Code Combination in CCC accessed via AHIN allows all services;
- Code Combination in CCC accessed via AHIN appends Modifier 51 to the secondary procedure(s) (Modifier 59 may be included in situations where it is necessary to identify a different lesion, session, etc., not defined by a more specific modifier. Colonoscopy procedures discussed separately in this newsletter is an example.)
- Code Combination in CCC accessed via AHIN replaces the two codes with one code that describes both services (i.e., 93501 + 93510 = 93526)
- One upper and one lower GI Endoscopy procedure. The two procedures address different areas of the body based on definition
- Evaluation and Management plus radiology plus one surgical procedure. In this scenario, modifier 59 is not appropriate on the surgical procedure. If the E&M code meets the conditions described by modifier 25, then the appropriate coding is to add modifier 25 to the E&M procedure.
- Physical therapy procedures: It is a common practice to provide multiple modalities on the same day. The descriptors provide information on the differences without appending Modifier 59.
- ALL clinical laboratory services billed on one day.
- Line items billed separately with RT and LT modifiers. These modifiers distinguish the different sites without the use of Modifier 59.
- E&M and surgery on the same day. If the E&M service meets the conditions of Modifier 25, Modifier 25 should be appended to the E&M service. It is never appropriate to also bill 59 with the surgical procedure.
- Outpatient facility claims where only one surgical procedure was performed. All ancillary, lab and radiology services will be combined with the surgical procedure and reimbursed based on the outpatient surgery fee schedule.
- G0351 is not included in G0347/G0348. There is no need to bill Modifier 59 with this procedure combination or with the code for the drug injected, i.e., EPO.

Effective October 1, 2005, Arkansas Blue Cross will begin DENYING line items billed inappropriately with Modifier 59.

Colonoscopy Guidelines:

The following coding guidelines were sent individually to the gastroenterologists listed in the Arkansas Blue Cross and Blue Shield provider file. If the physician/provider agrees to follow these coding guidelines, Arkansas Blue Cross will assume billing with Modifier 59 are appropriate and do not request medical records.

If a physician, ambulatory surgery center, or outpatient hospital submits these procedures for the circumstances described for Modifier 59 and have not sent a written agreement to follow these guidelines, please forward the written agreement to:

Arkansas Blue Cross and Blue Shield
- Corporate Medical Director Division
P.O. Box 2181
Little Rock, AR 72203-2181

(501) 378-3240
FAX (501) 399-3967

For all physicians, ambulatory surgery centers, or outpatient hospitals that do not send the written agreement by August 1, 2005, Arkansas Blue Cross will automatically deny the following CPT codes when billed with a Modifier 59.

CPT Code 45378:
Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure) was introduced as a CPT code in 1979.

CPT Code 45378 is a covered code subject to medical necessity and Plan coding edits. It is restricted based on diagnosis code, contract exclusion, CPT coding instruction, and fragmentation. It is not allowed if billed with ICD-9 diagnosis code V76.51 (Screening procedure of colon).

Screening procedures are a contract exclusion unless the member has Wellness Benefits. If a colonoscopy is done for screening purposes, the procedure should be reported with HCPCS Code G0121.

If a diagnostic colonoscopy does not extend proximal to the splenic flexure, CPT Code 45378 should be reported with Modifier 52 appended. CPT Code 45378 is considered a fragmentation of CPT Codes 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, and 45392. All of these codes represent "surgical" endoscopy codes, and surgical endoscopy codes include diagnostic endoscopy based on CPT coding instructions.

CPT Code 45378 should be denied if reported with any of the codes in the range 45379-45387 whether billed with Modifier 51 or 59. It is inclusive of conscious sedation.

CPT Code 45379:
Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body was introduced as a CPT code in 1979.

CPT Code 45379 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service and CPT coding instructions. It is restricted to one unit-of-service no matter how many foreign bodies are removed based on CPT coding instructions (CPT Assistant).

CPT Code 45379 is inclusive of conscious sedation based on CPT coding information. If it is performed during the same session, but on a separate lesion as CPT Code 45380, 45382, 45383, 45384, 45385, 45386, 45387, 45391, or 45392, it should be reported with Modifier 51 to identify the procedure as a multiple procedure.

(Continued on page 26)

(Continued from page 25)

When CPT Codes 45380-51 are billed with the proceeding codes, CPT Codes 45379-51 are allowed based on multiple procedure rules. If CPT Code 45379 is performed on the same day as CPT Code 45381, 45381 is paid based on multiple procedure rules. If a colonoscopy with foreign body removal does not extend proximal to the splenic flexure, CPT Code 45379 should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45380:

Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple was introduced into CPT coding prior to 1974.

CPT Code 45380 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service and CPT coding instructions. It is restricted to one unit-of-service no matter how many biopsies are done, whether done as multiple biopsies on the same lesion, or biopsies of multiple lesions, based on CPT coding instructions (CPT Assistant) and code descriptor. It is inclusive of conscious sedation based on CPT coding information.

If it is performed during the same procedure, but on a separate lesion as CPT Code 45383, 45384, or 45385, CPT Code 45380 should be reported with Modifier 59 to identify the separate lesion. When CPT Code 45380-59 is billed with CPT Code 45382, 45383, 45384, or 45385, it is allowed based on multiple procedure rules.

If CPT Code 45380 is performed during the same procedure as CPT Code 45379, 45386, 45387, 45391, or 45392, it should be billed with Modifier 51 to identify the procedure as a multiple procedure. If it is performed on the same day as CPT Code 45381, CPT Code 45381 is paid based on multiple procedure rules. If a colonoscopy with biopsy does not extend proximal to the splenic flexure, CPT Code 45380 should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45381:

Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance was introduced in 2003.

CPT Code 45381 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service, CPT coding instructions and fragmentation. It is restricted to one unit-of-service no matter how many injections are done based on CPT coding instructions (CPT Assistant).

CPT Code 45381 is inclusive of conscious sedation based on CPT coding information. If it is performed during the same session CPT Code 45379, 45380, 45382, 45383, 45384, 45385, 45386, 45387, 45391, or 45392, CPT Code 45381 should be reported with Modifier 51 to identify the procedure as a multiple procedure.

When 45381-51 is billed with the above codes, CPT Code 45381-51 is allowed based on multiple procedure rules. If a colonoscopy with submucosal injection does not extend proximal to the splenic flexure, CPT Code 45381 should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45382:

Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding [eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator] was introduced in 1979.

CPT Code 45382 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service, CPT coding instructions and fragmentation. It is restricted to one unit-of-service no matter how many injections are done based on CPT coding instructions (CPT Assistant).

CPT Code 45382 is inclusive of conscious sedation based on CPT coding information. It is a fragmentation of CPT Codes 45378, 45379, 45380, 45383, 45384, 45385, 45386, and 45387, if performed during the same session as one or more of these procedures, and the bleeding is as a result of one of these procedures.

If CPT Code 45382 is performed on a separate area of the colon other than the area where CPT Codes 45378-45387 are performed, it the procedure as a separate procedure. If a colonoscopy with control of bleeding does not extend proximal to the splenic flexure, it should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45383:
Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique was introduced in 1985.

CPT Code 45383 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service, and CPT coding instructions. It is restricted to one unit-of-service no matter how many ablations are done, whether done as multiple ablations on the same lesion, or ablation of multiple lesions, based on CPT coding instructions (CPT Assistant) and code descriptor.

CPT Code 45383 is inclusive of conscious sedation based on CPT coding information. If it is performed on a separate lesion from CPT Code 45384 or 45385, CPT Code 45384 and 45385 should be reported with Modifier 59 to identify the separate lesion. If a colonoscopy with biopsy does not extend proximal to the splenic flexure, CPT Code 45380 should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45384:
Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery was introduced in 1994.

CPT Code 45384 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service and CPT coding instructions. It is restricted to one unit-of-service no matter how many biopsies or cauterizations are done, whether done as multiple biopsies/cauterizations on the same lesion, or biopsies/cauterizations of multiple lesions, based on CPT coding instructions (CPT Assistant) and code descriptor.

CPT Code 45384 is inclusive of conscious sedation based on CPT coding information. If it is performed during the same procedure, but on a separate lesion as CPT Code 45383 or 45385, it should be reported with Modifier 59 to identify the separate lesion. When 45384-59 is billed with CPT Code 45383 or 45385, 45384-59 is allowed based on multiple procedure rules.

If CPT Code 45384 is performed during the same procedure as CPT Code 45387, 45391, or 45392, it should be billed with Modifier 51 to identify the procedure as a multiple procedure. If a colonoscopy with biopsy/cauterization does not extend proximal to the splenic flexure, it should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45385:
Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique was introduced into CPT coding prior to 1974.

CPT Code 45385 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service and CPT coding instructions. It is restricted to one unit-

(Continued on page 28)

(Continued from page 27)

of-service no matter how many snare removals are done, whether done as multiple snare removals on the same lesion, or snare removals of multiple lesions, based on CPT coding instructions (CPT Assistant) and code descriptor.

CPT Code 45385 is inclusive of conscious sedation based on CPT coding information. If it is performed during the same procedure, but on a separate lesion as CPT Code 45383, it should be reported with Modifier 59 to identify the separate lesion. When 45385-59 is billed with CPT Code 45383, 45385-59 is allowed based on multiple procedure rules. If it is billed with CPT Code 45383 performed on the same lesion, only CPT Code 45383 should be reported, based on CPT coding instructions (CPT Assistant, February 1999).

If CPT Code 45385 is performed during the same procedure as CPT Code 45387, 45391, or 45392, it should be billed with Modifier 51 to identify the procedure as a multiple procedure. If a colonoscopy with snare does not extend proximal to the splenic flexure, CPT Code 45385 should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45386:

Colonoscopy, flexible; with dilation by balloon, 1 or more strictures was introduced in 2003.

CPT Code 45386 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service, CPT coding instructions, and fragmentation. It is restricted to one unit-of-service no matter how many dilations of the same stricture, or dilations of multiple strictures, are performed, based on CPT code descriptor.

CPT Code 45386 is inclusive of conscious sedation based on CPT coding information. If it is performed during the same procedure, but on a separate lesion as CPT Code 45383, 45384, 45385, 45391, or 45392, it should be reported with Modifier 51 to identify multiple procedures. It is a fragmentation of CPT Code 45387 based on CPT coding instructions.

CPT Code 45387:

Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement [includes predilation] was introduced in 2001.

CPT Code 45387 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on site-of-service, units-of-service, CPT coding instructions, and fragmentation. It is subject to site-of-service differential.

There is not an RVU for CPT Code 45387 in place-of-service "non-facility". The safety of this procedure performed in a non-facility setting has not been established. There is no payment for CPT Code 45387 in place-of-service "non-facility". It is restricted to one unit-of-service. It is inclusive of conscious sedation based on CPT coding information.

CPT Code 45378:

Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure was introduced in 1979.

CPT Code 45378 is a covered code subject to medical necessity and Plan coding edits. It is restricted based on diagnosis code, contract exclusion, CPT coding instruction and fragmentation. It is not allowed if billed with ICD-9 diagnosis code V76.51 (Screening procedure of colon). Screening procedures are a contract exclusion unless the member has the Wellness Benefit.

If a colonoscopy is done for screening, the procedure should be reported with HCPCS G0121. If a diagnostic colonoscopy does not extend proximal to the splenic flexure, CPT

Code 45378 should be reported with Modifier 52 appended. It is considered a fragmentation of CPT Code 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, and 45392, as these codes represent "surgical" endoscopy codes. Surgical endoscopy codes include diagnostic endoscopy based on CPT coding instructions. CPT Code 45378 should be denied if reported with any of the codes in the range 45379-45387 whether billed with Modifier 51 or 59. It is inclusive of conscious sedation.

CPT Code 45379:
Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body was introduced in 1979.

CPT Code 45379 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service and CPT coding instructions. It is restricted to one unit-of-service no matter how many foreign bodies are removed based on CPT coding instructions (CPT Assistant).

CPT Code 45379 is inclusive of conscious sedation based on CPT coding information. If it is performed during the same session, but on a separate lesion as CPT Code 45380, 45382, 45383, 45384, 45385, 45386, 45387, 45391, or 45392, CPT Code 45379 should be reported with Modifier 51 to identify the procedure as a multiple procedure. When 45380-51 is billed with the above codes, it is allowed based on multiple procedure rules.

If CPT Code 45379 is performed on the same day as CPT Code 45381, code 45381 is paid based on multiple procedure rules. If a colonoscopy with foreign body removal does not extend proximal to the splenic flexure, it should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45380:
Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple was introduced prior to 1974.

CPT Code 45380 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service and CPT coding instructions. It is restricted to one unit-of-service no matter how many biopsies are done, whether done as multiple biopsies on the same lesion, or biopsies of multiple lesions, based on CPT coding instructions (CPT Assistant) and code descriptor.

CPT Code 45380 is inclusive of conscious sedation based on CPT coding information. If it is performed during the same procedure, but on a separate lesion as CPT Code 45383, 45384, or 45385, CPT Code 45380 should be reported with Modifier 59 to identify the separate lesion. When 45380-59 is billed with CPT Code 45382, 45383, 45384, or 45385, it is allowed based on multiple procedure rules.

If CPT Code 45380 is performed during the same procedure as CPT Code 45379, 45386, 45387, 45391, or 45392, it should be billed with Modifier 51 to identify the procedure as a multiple procedure. If it is performed on the same day as CPT Code 45381, CPT Code 45381 is paid based on multiple procedure rules. If a colonoscopy with biopsy does not extend proximal to the splenic flexure, CPT Code 45380 should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45381:
Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance was introduced in 2003.

CPT Code 45381 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service, CPT coding instructions and fragmentation. It is restricted

(Continued on page 30)

(Continued from page 29)

to one unit-of-service no matter how many injections are done based on CPT coding instructions (CPT Assistant). It is inclusive of conscious sedation based on CPT coding information.

If CPT Code 45381 is performed during the same session CPT Code 45379, 45380, 45382, 45383, 45384, 45385, 45386, 45387, 45391, or 45392, it should be reported with Modifier 51 to identify the procedure as a multiple procedure. When 45381-51 is billed with the above codes, CPT Code 45381-51 is allowed based on multiple procedure rules. If a colonoscopy with submucosal injection does not extend proximal to the splenic flexure, CPT Code 45381 should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45382:

Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding [eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator] was introduced in 1979.

CPT Code 45382 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service, CPT coding instructions and fragmentation. It is restricted to one unit-of-service no matter how many injections are done based on CPT coding instructions (CPT Assistant).

CPT Code 45382 is inclusive of conscious sedation based on CPT coding information. It is a fragmentation of CPT Code 45378, 45379, 45380, 45383, 45384, 45385, 45386, or 45387, if performed during the same session as one or more of these procedures and the bleeding is as a result of one of these procedures.

If CPT Code 45382 is performed on a separate area of the colon other than the area where CPT Code 45378-45387 is performed, it should be reported with Modifier 59 to identify the procedure as a separate procedure. If a colonoscopy with control of bleeding does not extend proximal to the splenic flexure, CPT Code 45382 should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45383:

Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique was introduced in 1985.

CPT Code 45383 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service, and CPT coding instructions. It is restricted to one unit-of-service no matter how many ablations are done, whether done as multiple ablations on the same lesion, or ablation of multiple lesions, based on CPT coding instructions (CPT Assistant) and code descriptor.

CPT Code 45383 is inclusive of conscious sedation based on CPT coding information. If it is performed on a separate lesion from CPT Code 45384 or 45385, CPT Code 45384 and 45385 should be reported with Modifier 59 to identify the separate lesion. If a colonoscopy with biopsy does not extend proximal to the splenic flexure, CPT Code 45380 should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45384:

Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery was introduced in 1994.

CPT Code 45384 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service and CPT coding instructions. It is restricted to one unit-of-service no matter how many biopsies or

cauterizations are done, whether done as multiple biopsies/cauterizations on the same lesion, or biopsies/cauterizations of multiple lesions, based on CPT coding instructions (CPT Assistant) and code descriptor.

CPT Code 45384 is inclusive of conscious sedation based on CPT coding information. If CPT Code 45384 is performed during the same procedure, but on a separate lesion as CPT Code 45383 or 45385, it should be reported with Modifier 59 to identify the separate lesion. When 45384-59 is billed with CPT Code 45383 or 45385, it is allowed based on multiple procedure rules.

If CPT Code 45384 is performed during the same procedure as CPT Code 45387, 45391, or 45392, it should be billed with Modifier 51 to identify the procedure as a multiple procedure. If a colonoscopy with biopsy/cauterization does not extend proximal to the splenic flexure, it should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45385:
Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique was introduced prior to 1974.

CPT Code 45385 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service and CPT coding instructions. It is restricted to one unit-of-service no matter how many snare removals are done, whether done as multiple snare removals on the same lesion, or snare removals of multiple lesions, based on CPT coding instructions (CPT Assistant) and code descriptor.

CPT Code 45385 is inclusive of conscious sedation based on CPT coding information. If it is performed during the same procedure, but on a separate lesion as CPT Code 45383, it should be reported with Modifier 59 to identify the separate lesion. When 45385-59 is billed with CPT Code 45383, CPT Code 45385-59 is allowed based on multiple procedure rules.

If CPT Code 45385 is billed with CPT Code 45383 performed on the same lesion, only CPT Code 45383 should be reported, based on CPT coding instructions (CPT Assistant, February 1999). If it is performed during the same procedure as CPT Code 45387, 45391, or 45392, CPT Code 45385 should be billed with Modifier 51 to identify the procedure as a multiple procedure. If a colonoscopy with snare does not extend proximal to the splenic flexure, CPT Code 45385 should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45386:
Colonoscopy, flexible; with dilation by balloon, 1 or more strictures was introduced in 2003.

CPT Code 45386 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service, CPT coding instructions, and fragmentation. It is restricted to one unit-of-service no matter how many dilations of the same stricture, or dilations of multiple strictures, are performed, based on CPT code descriptor.

CPT Code 45386 is inclusive of conscious sedation based on CPT coding information. If it is performed during the same procedure, but on a separate lesion as CPT Code 45383, 45384, 45385, 45391, or 45392, CPT Code 45386 should be reported with Modifier 51 to identify multiple procedures. CPT Code 45386 is a fragmentation of CPT Code 45387 based on CPT coding instructions.

CPT Code 45387:
Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement [includes predilation]) was introduced into CPT in 2001.

(Continued on page 32)

(Continued from page 31)

CPT Code 45387 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on site-of-service, units-of-service, CPT coding instructions, and fragmentation. It is subject to site-of-service differential. There is not an RVU for CPT Code 45387 in place-of-service "non-facility". The safety of this procedure performed in a non-facility setting has not been established. There is no payment for this code in place-of-service "non-facility".

CPT Code 45387 is restricted to one unit-of-service. It is inclusive of conscious sedation based on CPT coding information.

CPT Code 45378:
Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure) was introduced in 1979.

CPT Code 45378 is a covered code subject to medical necessity and Plan coding edits. It is restricted based on diagnosis code, contract exclusion, CPT coding instruction and fragmentation. It is not allowed if billed with ICD-9 diagnosis code V76.51 (Screening procedure of colon).

Screening procedures are a contract exclusion unless the member has the Wellness Benefit. If colonoscopy is done for screening, the procedure should be reported with HCPCS G0121.

If a diagnostic colonoscopy does not extend proximal to the splenic flexure, CPT Code 45378 should be reported with Modifier 52 appended. It is considered a fragmentation of CPT Codes 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, and 45392, as all of these codes represent "surgical" endoscopy codes. Surgical endoscopy codes include diagnostic endoscopy based on CPT coding instructions. CPT Code 45378 should be denied if reported with any of the codes in the range 45379-45387 whether billed with Modifier 51 or 59. CPT Code 45378 is inclusive of conscious sedation.

CPT Code 45379:
Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body was introduced in 1979.

CPT Code 45379 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service and CPT coding instructions. It is restricted to one unit-of-service no matter how many foreign bodies are removed based on CPT coding instructions (CPT Assistant).

CPT Code 45379 is inclusive of conscious sedation based on CPT coding information. If it is performed during the same session, but on a separate lesion as CPT Code 45380, 45382, 45383, 45384, 45385, 45386, 45387, 45391, or 45392, CPT Code 45379 should be reported with Modifier 51 to identify the procedure as a multiple procedure. When 45380-51 is billed with the above codes, CPT Code 45379-51 is allowed based on multiple procedure rules.

If CPT Code 45379 is performed on the same day as CPT Code 45381, 45381 is paid based on multiple procedure rules. If a colonoscopy with foreign body removal does not extend proximal to the splenic flexure, CPT Code 45379 should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45380:
Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple was introduced prior to 1974.

CPT Code 45380 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service and CPT coding instructions. It is restricted to one unit-

of-service no matter how many biopsies are done, whether done as multiple biopsies on the same lesion, or biopsies of multiple lesions, based on CPT coding instructions (CPT Assistant) and code descriptor.

CPT Code 45380 is inclusive of conscious sedation based on CPT coding information. If it is performed during the same procedure, but on a separate lesion as CPT Code 45383, 45384, or 45385, it should be reported with Modifier 59 to identify the separate lesion. When 45380-59 is billed with CPT Code 45382, 45383, 45384, or 45385, it is allowed based on multiple procedure rules.

If CPT Code 45380 is performed during the same procedure as CPT Code 45379, 45386, 45387, 45391, or 45392, CPT Code 45380 should be billed with Modifier 51 to identify the procedure as a multiple procedure. If it is performed on the same day as CPT Code 45381, code 45381 is paid based on multiple procedure rules. If a colonoscopy with biopsy does not extend proximal to the splenic flexure, CPT Code 45380 should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45381:
Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance was introduced in 2003.

CPT code is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service, CPT coding instructions and fragmentation. It is restricted to one unit-of-service no matter how many injections are done based on CPT coding instructions (CPT Assistant).

CPT Code 45381 is inclusive of conscious sedation based on CPT coding information. If it is performed during the same session CPT Code 45379, 45380, 45382, 45383, 45384, 45385, 45386, 45387, 45391, or 45392, CPT Code 45381 should be reported with Modifier 51 to identify the procedure as a multiple procedure. When 45381-51 is billed with the above codes, CPT Code 45381-51 is allowed based on multiple procedure rules. If a colonoscopy with submucosal injection does not extend proximal to the splenic flexure, CPT Code 45381 should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45382:
Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding [eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator] was introduced in 1979.

CPT Code 45382 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service, CPT coding instructions and fragmentation. It is restricted to one unit-of-service no matter how many injections are done based on CPT coding instructions (CPT Assistant).

CPT Code 45382 is inclusive of conscious sedation based on CPT coding information. It is a fragmentation of CPT Code 45378, 45379, 45380, 45383, 45384, 45385, 45386, or 45387, if performed during the same session as one or more of these procedures, and the bleeding is as a result of one of these procedures.

If CPT Code 45382 is performed on a separate area of the colon other than the area where CPT Code 45378-45387 is performed, CPT Code 45382 should be reported with Modifier 59 to identify the procedure as a separate procedure. If a colonoscopy with control of bleeding does not extend proximal to the splenic flexure, CPT Code 45382 should be reported with Modifier 52 appended, based on CPT coding instructions.

(Continued on page 34)

(Continued from page 33)

CPT Code 45383:
Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique was introduced in 1985.

CPT Code 45383 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service, and CPT coding instructions. It is restricted to one unit-of-service no matter how many ablations are done, whether done as multiple ablations on the same lesion, or ablation of multiple lesions, based on CPT coding instructions (CPT Assistant) and code descriptor.

CPT Code 45383 is inclusive of conscious sedation based on CPT coding information. If it is performed on a separate lesion from CPT Code 45384 or 45385, CPT Code 45384 and 45385 should be reported with Modifier 59 to identify the separate lesion. If a colonoscopy with biopsy does not extend proximal to the splenic flexure, CPT Code 45380 should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45384:
Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery was introduced in 1994.

CPT Code 45384 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service and CPT coding instructions. It is restricted to one unit-of-service no matter how many biopsies or cauterizations are done, whether done as multiple biopsies/cauterizations on the same lesion, or biopsies/cauterizations of multiple lesions, based on CPT coding instructions (CPT Assistant) and code descriptor.

CPT Code 45384 is inclusive of conscious sedation based on CPT coding information. If it is performed during the same procedure, but on a separate lesion as CPT Code 45383 or 45385, CPT Code 45384 should be reported with Modifier 59 to identify the separate lesion. When 45384-59 is billed with CPT Code 45383 or 45385, it is allowed based on multiple procedure rules.

If CPT Code 45384 is performed during the same procedure as CPT Code 45387, 45391, or 45392, it should be billed with Modifier 51 to identify the procedure as a multiple procedure. If a colonoscopy with biopsy/cauterization does not extend proximal to the splenic flexure, CPT Code 45384 should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45385:
Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique was introduced prior to 1974.

CPT Code 45385 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service and CPT coding instructions. It is restricted to one unit-of-service no matter how many snare removals are done, whether done as multiple snare removals on the same lesion, or snare removals of multiple lesions, based on CPT coding instructions (CPT Assistant) and code descriptor.

CPT Code 45385 is inclusive of conscious sedation based on CPT coding information. If it is performed during the same procedure, but on a separate lesion as CPT Code 45383, CPT Code 45385 should be reported with Modifier 59 to identify the separate lesion. When 45385-59 is billed with CPT Code 45383, CPT Code 45385-59 is allowed based on multiple procedure rules.

If CPT Code 45385 is billed with CPT Code 45383 performed on the same lesion, only CPT Code 45383 should be reported, based on CPT coding instructions (CPT Assistant, February 1999). If it is performed during the same procedure as CPT Code 45387, 45391, or 45392, CPT Code 45385 should be billed with Modifier 51 to identify the procedure as a multiple procedure. If a colonoscopy with snare does not extend proximal to the splenic flexure, CPT Code 45385 should be reported with Modifier 52 appended, based on CPT coding instructions.

CPT Code 45386:
Colonoscopy, flexible; with dilation by balloon, 1 or more strictures was introduced in 2003.

CPT Code 45386 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on units-of-service, CPT coding instructions, and fragmentation. It is restricted to one unit-of-service no matter how many dilations of the same stricture, or dilations of multiple strictures, are performed, based on CPT code descriptor. It is inclusive of conscious sedation based on CPT coding information.

If CPT Code 45386 is performed during the same procedure, but on a separate lesion as CPT Code 45383, 45384, 45385, 45391, or 45392, it should be reported with Modifier 51 to identify multiple procedures. CPT Code 45386 is a fragmentation of CPT Code 45387 based on CPT coding instructions.

CPT Code 45387:
Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement [includes predilation] was introduced in 2001.

CPT Code 45387 is a covered code, subject to medical necessity and Plan coding edits. It is restricted based on site-of-service, units-of-service, CPT coding instructions, and fragmentation. It is subject to site-of-service differential. There is not an RVU for CPT Code 45387 in place-of-service "non-facility". The safety of this procedure performed in a non-facility setting has not been established. There is not a payment in place-of-service "non-facility". It is restricted to one unit-of-service. It is inclusive of conscious sedation based on CPT coding information.

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