EKG

**Question:** When an EKG is ordered by one provider and interpreted by another physician, we bill the code 93005 under the ordering provider and code 93010 under the interpreting physician. One payer is denying one of the components, telling us that we must bill the global code 93000. The reimbursement is the same whether billed using codes 93005/93010 versus 93000 so we believe this is an inappropriate denial. What is your policy regarding EKG billing?

**Question for:** Third Party Payer | Medicaid | Medicare

**Code:** 93000, 93005, 93010

**Setting:**

**Providers:** Medical physician

**Submitted by:** Barb Faber

Agnesian HealthCare

Director of Managed Care and Professional Billing

barbara.faber@ssmhealth.com | 926-8333

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**WEA Response:** We would expect that within the same clinic, the most comprehensive code (93000) would be used.

**Physicians Plus, Quartz Affiliate:** Physicians Plus would allow the 93005 & 93010 as long as providers are of different specialties.

**Security Health Plan:** Billing CPT 93005 and CPT 93010 is allowed when done by two physicians with differing specialties.

**ANSWER: National Government Services, Inc. (Medicare)**

93000 - Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report.

93005 - Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report.

93010 - Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only.

When a provider performs the entire global procedure they bill 93000. When one provider performs the technical component (tracing only), they would bill 93005. When a different provider performs the professional component (interpretation and report only), they would bill 93010.

**ForwardHealth:** ForwardHealth does not have published coverage policy guidelines for EKG billing. Providers should refer to the appropriate Max Fee schedule for allowable services.

**Cigna:** Cigna does not allow 93005 only 93010 and 93000 to be billed on the same date.
Anthem response: Claims should be submitted in accordance with the reporting guidelines and instructions contained in the American Medical Association (AMA) CPT codebook, “CPT Assistant,” HCPCS, ASA Relative Value Guide, and ICD-10-CM publications. Billing would be based on the description of the procedure performed. 93000 includes the ECG with interpretation and report. 93005 is the tracing only without interpretation and report and 93010 is the interpretation and report only. We would expect providers to bill global if both the test and interpretation was performed by the same physician. If the services are performed by two different physicians, then they can bill separately. Currently a rejection to bill global should not be present for local Anthem commercial members.

WPS: If the services are being provided by two different providers the individual components would be allowed. If the services were provided by the same provider, then the components would be denied stating billing of the global code would be more appropriate.
Payment for Two Services

**Question:** We receive denials for code 93010 when billed with an evaluation and management code. The codes are not bundled per CCI and a 25 modifier is appended to the E/M, indicating that the services are significantly different and typically occur at a different time. Do you allow payment for both services?

**Question for:** Third Party Payer

**Code:** 93010 with Evaluation and Management Code

**Setting:**

**Providers:** physicians

**Submitted by:** Barb Faber

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Director of Managed Care and Professional Billing

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**WEA Response:** We currently pay without a modifier when the two are billed together.

**Physicians Plus, Quartz Affiliate:** Yes, we allow payment for both of these services.

**Security Health Plan:** If an E&M is billed with CPT 93010, and the E&M has a modifier 25 appended, and the documentation supports the separate billing of the E&M, then this billing scenario would be allowed.

**Cigna:** Cigna only allows 93000 to be billed with modifier 25

**Anthem Response:** Per Anthem Clinical Claim Edit 041 at this link:

[https://www11.anthem.com/shared/noapplication/f3/s5/t0/pw_043251.pdf?refer=ahpculdesac&na=customclaimedits](https://www11.anthem.com/shared/noapplication/f3/s5/t0/pw_043251.pdf?refer=ahpculdesac&na=customclaimedits) we bundle 93010 and 93042 as incidental to 99201-99239, 99241-99275 and 99381-99397. A review of an ECG report from a previously performed ECG is part of the performance of an evaluation and management service. Therefore, if 93010 or 93042 is submitted with 99201-99239, 99241-99275 or 99381-99397-- only 99201-99239, 99241-99275 or 99381-99397 reimburses.

**WPS:** We would allow payment on both codes
**Total Knee Replacement**

**Question:** Effective 1/1/18, Total Knee Replacement procedure was removed from Medicare's inpatient only list. Do you have criteria or guidelines that would identify a patient that would be appropriate for outpatient status versus inpatient status? What criteria is being used by your prior authorization teams or your post payment auditors to support inpatient versus outpatient status for this procedure?

**Question for:** Third Party Payer | Medicaid | Medicare

**Code:** 27447

**Setting:**

**Providers:** Physicians

**Submitted by:** Barb Faber

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Director of Managed Care and Professional Billing
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**WEA Response:** We use MCG criteria and they have specific guidelines for both inpatient and outpatient. It does require prior authorization regardless of place of service.

**Physicians Plus, Quartz Affiliate:** 27447 is covered without a referral if billed outpatient.

**Security Health Plan:** Precertification is required for inpatient status, and prior authorization is required for outpatient or ASC status. Medical necessity will dictate if inpatient or outpatient.

**ANSWER: National Government Services, Inc. (Medicare):** Medicare does not prior authorize anything except HBO and some dialysis ambulance services. We would expect there to be enough clinical information by the orthopedic surgeon to justify an admission. NGS has a Local Coverage Determination L36039 which includes the following information in the documentation section: In order to meet Medicare’s reasonable and necessary (R&N) threshold for coverage of a procedure, the documentation should clearly support both the diagnostic criteria for the indication (standard test results and/or clinical findings as applicable) and the medical need (the procedure does not exceed the medical need, is at least as beneficial as existing alternatives, and is furnished within accepted standards of medical practice in a setting appropriate for the patient’s medical needs and condition). Lacking compelling arguments for an exception in the supporting documentation, the hospital (FISS claim) and physician services (MCS claim) may be denied.

**ForwardHealth:** Per Physician Interactive Fee Schedule, procedure code 27447 is allowable for professional payment at both inpatient and outpatient place of service (POS) without Prior Authorization.
**Cigna:** Code: 27447 Attached coverage policy

**Anthem Response:** Precertification is required for knee replacement surgery regardless of the setting. Authorization is done via AIM for local Anthem members. Providers wishing to view details of the program including clinical tools are encouraged to view AIM’s Musculoskeletal Program microsite at [http://www.aimprovider.com/msk](http://www.aimprovider.com/msk)

**WPS:** We follow MGC guidelines (formerly known as Milliman) Guidelines are available for individual patient requests.
Manual Therapy and Electrical Stimulation

**Question:** Codes 97140 (Manual Therapy) and G0283 (Electrical Stimulation, unattended) were always considered non-covered by Medicare and denied with a PR denial. We were told that effective 1/1/18 these two codes are included in the physical therapy plan of care and must be appended with a QP modifier. This doesn't make sense for services provided by Chiropractors. If we don't append a QP modifier, the codes are denied with a CO denial, meaning that we can't bill the patient. Can we have the patient sign an ABN and append the GA modifier for a PR denial?

**Question for:** Medicare

**Code:** 97140 and G0283

**Setting:**

**Providers:** Chiropractors

**Submitted by:** Barb Faber

Agnesian HealthCare

Director of Managed Care and Professional Billing

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**Security Health Plan:** Our edits for Physical Therapy do not apply to Chiropractic providers and we do not require Physical Therapy modifiers on Chiropractic services.

**ANSWER: National Government Services, Inc. (Medicare)**

(Responses to these questions were sent previously to this groups inquiries)

The therapy plan modifier you refer to is GP, not a QP. Providers should refer to MLN article 10176 that advises a hard-coded edit was to be installed in MCS with the January 2018 release which requires one of the therapy modifiers (GN, GO or GP) must be reported with the codes listed in that change request regardless of specialty. The J6 State Chiropractic Associations have notified their members and NGS has also posted a notice to report the GY modifier but also include the GP modifier. We understand the concern about chiropractors reporting a modifier GP but their claims will reject otherwise. Since this is a hard-coded edit, we do not have the ability to make any changes. As far as an ABN being used, this would not be appropriate. The ABN is used when a provider believes some or all of the services being performed will deny based on medical necessity, which, with this situation, is not the case.

(An article was also posted on the NGSMedicare.com website titled “Chiropractic Noncovered Therapy Service Billing to Medicare”)
Anesthesia Code

Question: What anesthesia code do you expect the provider to submit when a patient presents for a screening colonoscopy but a polyp is removed. There is conflicting information on how this should be coded by the anesthesiologist since it is still considered a screening colonoscopy.

Question for: Third Party Payer | Medicaid | Medicare

Code: Anesthesia codes 00811 and 00812

Setting:

Providers: Anesthesiology providers

Submitted by: Barb Faber

Agnesian HealthCare
Director of Managed Care and Professional Billing

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WEA Response: Medicare - MLN -MM10181- is an article that instructs you on how to use these codes. It was also addressed at the AMA conference in November. We follow the same guideline.

Physicians Plus, Quartz Affiliate: We can’t advise on how to code, however, we would recommend to use the code that best matches the service.

Security Health Plan: Most of our Commercial plans allow one colonoscopy paid as preventive annually, whether billed as a screening or not. Associated charges, such as anesthesia, would pay as the preventive colonoscopy was paid.

ANSWER: National Government Services, Inc. (Medicare): Effective January 1, 2018, CR 10181 (MLN MM10181) titled “Replacement of Mammography HCPCS Codes, Waiver of Coinsurance and Deductible for Preventive and Other Services, and Addition of Anesthesia and Prolonged Preventive Services”, included the following information for billing anesthesia in the above mentioned circumstance.

When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to duodenum; not otherwise specified) and with the PT modifier. CPT code 00811 will be added as part of the January 1, 2018 HCPCS update. Effective for claims with dates of service on or after January 1, 2018, Medicare will pay claim lines with new CPT code 00811 and waive only the deductible when submitted with the PT modifier.

ForwardHealth: ForwardHealth does not have published coverage policy guidelines for colonoscopy anesthesia. Providers should refer to the appropriate Max Fee schedule for allowable services.

Cigna: Code: Anesthesia codes 00811 and 00812 --Cigna allows either code to be billed.
**Anthem Response:** Claims should be submitted in accordance with the reporting guidelines and instructions contained in the American Medical Association (AMA) CPT codebook, "CPT Assistant," HCPCS, ASA Relative Value Guide, and ICD-10-CM publications. Please refer to parenthetical notes found on page 62 of the AMA CPT 2018 Professional which indicate report 00812 to describe anesthesia for any screening colonoscopy regardless of ultimate findings.

**WPS:** For screening the appropriate code appears to be 00812
Surgical Assists

**Question:** Do payers expect to be billed at full fee or reduced fee for surgical assists (modifiers AS, 80, etc.)

**Question for:** Third Party Payer | Medicaid | Medicare

**Code:**

**Setting:**

**Providers:** All

**Submitted by:** Dean Cravilion
Prevea Health
Director of Business Office
dean.cravillion@prevea.com | 920-431-1951

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**WEA Response:** Our Provider Manual (on our website WWW.WEATRUST.com) indicates that we will take a reduction for the surgical assist modifiers. That would indicate that you should bill the full amount.

**Physicians Plus, Quartz Affiliate:** We expect providers to bill the full fee and our system will take a reduction upon adjudication.

**Security Health Plan:** We expect providers to bill full fee. We, along with our repricers, reduce modifiers when the claim is processed, based on the modifier billed.

**ANSWER: National Government Services, Inc. (Medicare):** Assistant Surgeons fees for Medicare, are allowed at a rate of 16% of the Fee Schedule allowance for that service. If a participating provider is billing as an assistant surgeon, the billed amount can be their real world fee as the Assistant surgeon modifier is a pricing modifier, and will reduce the payment in the processing system.

A non-participating provider would have to consider the limiting charge. Where they cannot charge the patient more than the limiting charge of the non-participating fee schedule allowance, and should consider that with their submitted fee.

**Forward Health:** Medicaid expects to be billed at provider’s Usual & Customary fee.

**Cigna:** Cigna allows full fee to be billed with the appropriate modifier.

**Anthem Response:** Providers should bill the full amount as reductions are applied during claim processing.

**WPS:** We expect providers to bill full fee for all services provided
Cataract Surgery

Question: This procedure is performed prior to cataract surgery. According to Medicare's guidelines, the code is considered a bilateral technical component but unilateral professional component. We must bill the following scenario to Medicare: 76519 (global for surgical eye) and 76519-26 (professional only for the non-surgical eye. Needed for comparison). Do you reimburse this procedure according to CMS guidelines?

Question for: Third Party Payer | Medicaid | Medicare

Code: 76519

Setting:

Providers: Physician performed in clinic setting

Submitted by: Barb Faber

Agnesian HealthCare

Director of Managed Care and Professional Billing

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WEA Response: We would consider it for payment if it came in this way, but we do not require that it be done this way in order to pay it.

Physicians Plus, Quartz Affiliate: As MUE is 2, we would allow for two full components of this code to be billed.

Security Health Plan: We follow Medicare guidelines.

ANSWER: National Government Services, Inc. (Medicare): Yes. We are a Medicare contractor. Thus we follow all CMS regulations. This is discussed in Local Coverage Determination (LCD): Ophthalmic Biometry for Intraocular Lens Power Calculation (L33621)

ForwardHealth: ForwardHealth does not have published coverage policy guidelines for A scan. Providers should refer to the appropriate Max Fee schedule for allowable services.

Cigna: Cigna only allows billing of 76519-26.

Anthem Response: Yes, commercial plans reimburse the global 76519 and one 76519-26.

WPS: These codes would be reimbursed according to your contracted rates, however if performed on the same day by the same provider one will deny based on frequency of services.
FY Modifiers

**Question:** Is the FY modifier required on all x-rays when the imaging service is taken using computed radiology technology? Currently FFS Medicare requires the FY modifier. Is this required by Medicare advantage plans?

**Question for:** Third Party Payer | Medicare

**Code:** all x-ray codes

**Setting:**

**Providers:** clinic settings

**Submitted by:** Barb Faber

Agnesian HealthCare

Director of Managed Care and Professional Billing

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**WEA Response:** Yes, we would like the modifier to be used as indicated by Medicare.

**Physicians Plus, Quartz Affiliate:** Physicians Plus does not have a Medicare Advantage Plan, but follow CMS guidelines in regards to the FY modifier.

**Security Health Plan:** Our Commercial plans do not require modifier FY at this time.

**ANSWER: National Government Services, Inc. (Medicare):** National government Services does not process the claims for Medicare Advantage plans. Though, we have found many advantage plans do follow Medicare guidance. However, you will have to check with the specific Medicare Advantage Plan to see if they require and accept the FY modifier.

**Cigna:** Cigna requires this modifier to be billed.

**Anthem Response:** Yes. Please see Anthem Medicare Advantage Modifier Usage Reimbursement Policy at this link:

https://www11.anthem.com/shared/noapplication/f0/s0/t0/pw_e220009.pdf?refer=ahpprovider&state=wi

**WPS:** FA is not required. WPS does not have a Medicare Advantage plan.
Chemotherapy

Question: Patient receives intrathecal chemotherapy; however, Radiology performs the spinal puncture with fluoroscopic guidance while Oncology performs the chemotherapy administration. Would the following be appropriate for billing? Oncology would bill 96450-52 Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture. Radiology would also bill 96450-52, along with code 77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure).

Question for: Third Party Payer

Code: 96450

Setting:

Providers: MD

Submitted by: Jody McClain

UW Health

Director of Coding

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WEA Response: we would not expect to be billed in this manner. Essentially the full procedure was done and does not therefore require a 52 modifier. It would appear to us that the procedure was attempted twice and did not come to completion if billed this way.

Physicians Plus, Quartz Affiliate: We cannot advise providers how to apply billing/coding scenarios

Security Health Plan: No, we do not feel it is appropriate for both Oncology and Radiology to bill CPT 96450 with modifier 52. There is a more specific CPT code that better fits the service Radiology is providing.

Cigna: Cigna would allow is 96450 if billed with modifier 52 and 77003 with modifier 26.

Anthem Response: Yes, Code 96450 with modifier 52 x 2 can be billed by the same TIN. Modifier 52 will reduce reimbursement 50% of the allowable, therefore the TIN will be reimbursed 100% of their allowable for code 96450.

WPS: Currently no edits in the system for these code combinations.
New Breast Lump Codes

**Question:** - Breast Imaging: Breast Echography (Sonography)/Breast MRI/Ductography includes the new breast lump codes N63.11-N63.42. What is missing from the payable diagnosis section (group 1) of the LCD is the breast lump, unspecified quadrant codes N63.10 and N63.20, which are the codes we use for breast lumps located at the 12 o'clock, 3 o'clock, 6 o'clock or 9 o'clock position. Unlike the breast malignancy codes, the breast lump codes do not have a code for "overlapping sites" which is what we use when the malignancy is located in one of the positions mentioned above. Is it the intent of the LCD to not cover breast lumps located in these positions (12, 3, 6 or 9 o'clock)? If that is not the intention, can codes N63.10 and N63.20 be added to LCD L33585?

**Question for:** Medicare

**Code:** LCD L33585, N63.11-N63.42

**Setting:** Radiology

**Providers:** MD, DO

**Submitted by:** Jody McClain

UW Health
Director of Coding
Jody.McClain@uwmf.wisc.edu | 608-828-1801

ANSWER: National Government Services, Inc. (Medicare)

It is not appropriate to include unspecific codes in LCDs such as those requested. Providers should report the ICD-10-CM codes for both quadrants if they are not sure which quadrant is affected. In addition, CMS has not added these codes in the hard-coded edits for the mammography NCD (220.4)

Please refer to Q&A #7 in the Questions and Answers link below which is available on CMS' Web site.

Speech Pathology

**Question:** Do you reimburse Speech Pathology services for patients that have voice concerns unrelated to gender transition? Dx codes would be R49.0 or F64.0.

**Question for:** Third Party Payer | Medicaid | Medicare

**Code:** Speech Therapy - 92524, 92520, 31579, 92507

**Setting:** Clinic, Outpt hospital

**Providers:** SLP

**Submitted by:** Jody McClain

UW Health

Director of Coding

Jody.McClain@uwmf.wisc.edu | 608-828-1801

The WEA Response: this does require prior auth. We do not allow F64.0 for this group of CPT codes.

Physicians Plus, Quartz Affiliate: F64.0 is considered a benefit exclusion for Speech Pathology. We will allow for R49.0.

Security Health Plan: This would be determined by our Health Services area, as all speech therapy requires prior authorization.

**ANSWER: National Government Services, Inc. (Medicare):** National Government Services has an LCD (L33580) for Speech Language Pathology with a corresponding Supplemental Instruction Article (A5866) that outline the coverage and limits of coverage for speech and language pathology services. The LCD lists covered diagnosis. R49.0 is included F64.0 is not.

ForwardHealth: Providers should refer to the appropriate Max Fee schedule. ForwardHealth does not have diagnosis restrictions on these codes. All coverage guidelines for speech therapy must be adhered to.

Cigna: Cigna would allow all of these code except 92520.

**Anthem Response:** Coverage for Speech Pathology services is based on medical necessity and clinical guidelines. Anthem Clinical Guideline CG-REHAB-06 at this link:

https://www.anthem.com/medicalpolicies/guidelines/gl_pw_a051174.htm provides the criteria used in making this determination.

WPS Response: This is not a covered service
Speech Pathology – Gender Transition

**Question:** Do you reimburse Speech Pathology services for patients whose communication impairment is related only to gender transition? Dx codes would be R48.8 and F64.0.

**Question for:** Third Party Payer | Medicaid | Medicare

**Code:** Speech therapy - 92524, 92520, 31579, 92507

**Setting:** clinic, outpt hospital

**Providers:** SLP

**Submitted by:** Jody McClain

UW Health

Director of Coding

Jody.McClain@uwmf.wisc.edu | 608-828-1801

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**WEA Response:** we do not believe R48.8 should be used for gender transition. F64.0 would not be covered for gender transition as they are not specific enough diagnoses and it does not repair a functional impairment.

**Physicians Plus, Quartz Affiliate:** F64.0 is considered a benefit exclusion for Speech Pathology. We will allow for R49.0.

**Security Health Plan:** This will be determined by our Health Services area, as all speech therapy requires prior authorization.

**ANSWER: National Government Services, Inc. (Medicare):** National Government Services has an LCD (L33580) for Speech Language Pathology with a corresponding Supplemental Instruction Article (A5866) that outline the coverage and limits of coverage for speech and language pathology services. The LCD lists covered diagnosis. R48.8 is included F64.0 is not.

**ForwardHealth:** Providers should refer to the appropriate Max Fee schedule. ForwardHealth does not have diagnosis restrictions on these codes. All coverage guidelines for speech therapy must be adhered to.

**Cigna:** Speech therapy - 92524, 92520, 31579, 92507- Cigna would allow all of these code except 92520.

**Anthem Response:** Same response as above.

**WPS Response:** This is not a covered service
**Category III CPT**

**Question:** Are any payers considering adding Category III CPT 0449T to your payable list as it has been added to the ASC fee schedule as payable?

**Question for:** Third Party Payer | Medicaid | Medicare

**Code:** 0449T - XEN Stent

**Setting:** ASC

**Providers:** MD

**Submitted by:** Jody McClain

UW Health

Director of Coding

Jody.McClain@uwrf.wisc.edu | 608-828-1801

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**WEA Response:** We do not cover this procedure. We typically do not cover any category III codes.

**Physicians Plus, Quartz Affiliate:** Authorization will be required for reimbursement consideration.

**Security Health Plan:** This code is still considered to be experimental/investigational and is noncovered.

**ANSWER: National Government Services, Inc. (Medicare):** Category III code 0449T (INSERTION OF AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE SUBCONJUNCTIVAL SPACE; INITIAL DEVICE) can be found in National Government Services LCD 37244 (Micro-Invasive Glaucoma Surgery). This code can be considered medically necessary when the Indications of Coverage are met. The 90 day global period applies and would be paid.

**ForwardHealth:** ForwardHealth does not currently cover this service in any setting.

**Cigna:** Cigna does allow this CPT code when billed with the appropriate diagnosis code.

**Anthem Response:** Per Anthem Medical Policy SURG.00103 at this link: [https://www.anthem.com/medicalpolicies/policies/mp_pw_b088812.htm](https://www.anthem.com/medicalpolicies/policies/mp_pw_b088812.htm) provides the medical necessity criteria that must be met. 0499T (Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device [XEN Gel Stent]) is falling into the Investigational and Not Medically Necessary section of the policy. Please see the Rationale section for more information.

**WPS:** This is currently not covered, however is under review for future consideration of coverage.
Moderate Sedation

Question: Moderate Sedation - Do you prefer G0500 or 99152? Do you cover 99153?

Question for: Third Party Payer | Medicaid

Code:

Setting:

Providers:

Submitted by: Kellie Scholl

Ascension Medical Group, Wisconsin
System Clinic Coding Supervisor
Kellie.Scholl@ascension.org | 920 572.0928

WEA Response: We will cover any of the above codes if the provider billing it is the one incurring the costs for the person performing it.

Physicians Plus, Quartz Affiliate: We would accept either of these codes.

Security Health Plan: Either G0500 (gastrointestinal service only) or CPT 99152 is allowed. Yes, CPT 99153 is covered.

ForwardHealth: Per ForwardHealth Interactive Max Fee schedule:

Procedure code 99152 is covered.

Procedure code G0500 is not covered (addressed at the June 2017 WMGMA Mtg).

Procedure code 99153 is covered (addressed at the June 2017 WMGMA Mtg).

Cigna: These are all payable when billed with the appropriate diagnosis codes.

Anthem Response: It’s difficult to provide a definitive response to this question. In our January 2017 Network Update Newsletter there is information on reimbursement for Moderate (Conscious) Sedation Policy 0014 at this link: https://www11.anthem.com/provider/noapplication/f0/s0/t0/pw_g280341.pdf?refer=ahpprovider&state=wi. In the article we stated that we will continue with the concept that moderate (conscious) sedation, identified by new CPT codes 99151, 99152, 99153, 99155, 99156, and 99157, is included with the reimbursement for certain Health Plan designated surgical, diagnostic, or therapeutic procedures and such sedation is not eligible for separate reimbursement when reported by the physician or other qualified health care professional performing one of the designated procedures. These designated procedures were previously listed in the deleted CPT Appendix G and are now identified in our “Codes
that Include Moderate (Conscious) Sedation” list. Modifiers will not override the edits. Here is a link to the list of codes where Moderate (Conscious) Sedation is included: https://www11.anthem.com/provider/noapplication/f0/s0/t0/pw_g280340.pdf?refer=ahpprovider&state=wi. In additional and as indicated in our February, 2017 Network Update Newsletter, effective February 20, 2017, G0500 appears in section 1 of our Bundled Services and Supplies Reimbursement Policy as not separately reimbursed.

**WPS:** We cover either code.
Moderate Sedation – Modifier

**Question:** Do you require Modifier 33 or PT on the moderate sedation during a screening colonoscopy?

**Question for:** Third Party Payer | Medicaid

**Code:**

**Setting:**

**Providers:**

**Submitted by:** Kellie Scholl

- Ascension Medical Group, Ascension System Clinic Coding Supervisor
- Kellie.Scholl@ascension.org | 920 572-0928

**WEA Response:** It depends on whether it is considered preventive. Not all “screening” colonoscopies are truly done in the absence of signs or symptoms or past history.

**Physicians Plus, Quartz Affiliate:** We would accept either

**Security Health Plan:** Neither modifier 33 or PT is required for Commercial preventive care services.

**ForwardHealth:** Please refer to the ForwardHealth Interactive Max Fee schedule for allowable modifiers. No modifiers are required.

**Cigna:** Cigna does not require these modifiers to be billed for this procedure.

**Anthem Response:** According to Anthem professional reimbursement policies, sedation codes G0500 and 99153 will bundle with the colonoscopy code. So if providers bill the preventative diagnosis (even if the procedure does become diagnostic the preventative DX is always billed primary). Modifier 33 or PT would waive any patient cost share. Provider may review our Moderate (Conscious) Sedation (Policy 0014) professional reimbursement policy at this link:

https://www11.anthem.com/provider/noapplication/f0/s0/t0/pw_g280341.pdf?refer=ahpprovider&state=wi and our Bundled Services and Supplies (Policy 0008) professional reimbursement policy at this link:

https://www11.anthem.com/provider/noapplication/f0/s0/t0/pw_g319035.pdf?refer=ahpprovider&state=wi

**WPS:** The modifier 33 or PT is not required but is accepted if received on a claim.
Smear – Papanicolaou

**Question:** Do you reimburse for obtaining a papanicolaou smear - Q0091

**Question for:** Third Party Payer | Medicaid

**Code:** Q0091

**Setting:**

**Providers:** Submitted by: Kellie Scholl

- Ascension Medical Group, Wisconsin
- System Clinic Coding Supervisor
- Kellie.Scholl@ascension.org | 920 572-0928

**WEA Response:** We feel this should not be billed in addition to the pap smear itself and will not pay additionally for this code. This is a Medicare code used for payment of special exemptions. We would COB with Medicare if they allow it.

**Physicians Plus, Quartz Affiliate:** Yes

**Security Health Plan:** Yes, Q0091 is a covered service.

**ForwardHealth:** Please refer to the ForwardHealth Interactive Fee Schedule for allowable procedure codes. Procedure code Q0091 is allowable.

**Cigna:** Q0091-Cigna allows this code when billed with the appropriate diagnosis code.

**Anthem Response:** According to Clinical Claim Edit 305 at this link: [https://www11.anthem.com/provider/ky/5/s1/t0/pw_043495.pdf?na=custclaimsedits](https://www11.anthem.com/provider/ky/5/s1/t0/pw_043495.pdf?na=custclaimsedits), Anthem considers screening services are part of performing an evaluation and management services and therefore not reimbursed separately. Therefore, if Q0091 is submitted with 99201-99205, 99211-99215, 99217-99220, 99221-99239, 99281-99285, 99291-99292, 99304-99310, 99315-99316, 99318 99324-99328 99334-99337, 99341-99350, 99360, 99455-99456, 99460-99466, 99468-99469, 99471-99472, 99475-99480, 99499, 99381-99387, 99391-99397 or S0610-S0613—only 99201-99205, 99211-99215, 99217-99220, 99221-99239, 99281-99285, 99291-99292, 99304-99310, 99315-99316, 99318 99324-99328 99334-99337, 99341-99350, 99360, 99455-99456, 99460-99466, 99468-99469, 99471-99472, 99475-99480, 99499, 99381-99387, 99391-99397 or S0610-S0613 is reimbursable.

**WPS:** Q0091 is bundled into most of the preventative E& M codes and not separately reimbursable
Clarification – CPT 76942

**Question:** Can ForwardHealth provide more clarification on why CPT 76942 is not allowed in the place of service of ASC (POS 24)? It is allowed to be performed hospital outpatient and there are comparable codes (CPTs 77002 and 76937 for example) that are allowed in the ASC. Specifically, could ForwardHealth elaborate on why the professional portion (billed with a 26 modifier) would not be allowed in the ASC?

**Question for:** Medicaid

**Code:** 76942

**Setting:** ASC

**Providers:** Radiology

**Submitted by:** Carl Langhoff

Marshfield Clinic

Reimbursement Policy Analyst

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**ForwardHealth:** Further review is needed for this question. Providers will be notified if there are any coverage policy changes.
Modifier GT

**Question:** Will you be following Medicare in eliminating the need for modifier GT to be billed with telehealth services (as POS 02 is sufficient in identifying these services)?

**Question for:** Third Party Payer | Medicaid

**Code:** GT Modifier

**Setting:** Telehealth

**Providers:**

Submitted by: Carl Langhoff  
Marshfield Clinic  
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**WEA Response:** we do not require modifier GT when the POS is 02.

**Physicians Plus, Quartz Affiliate:** No. We still require the GT code for telehealth services at this time.

**Security Health Plan:** We will no longer require modifier GT.

**ForwardHealth:** Per Topic #510 – Telehealth, of your Online Physicians Handbook, both modifier GT and Place of Service code 02, are required for purposes of billing Telehealth services.

**Cigna:** At this time informational only, found under Cigna reimbursement Policy MHCPCS Healthcare Common Procedure Coding System (HCPCS) National Level II Modifier

**Anthem Response:** As indicated in our April, 2017 Network Update Newsletter, effective January 1, 2017, Anthem is following CMS in implementing new place of service code 02. The new place of service code 02 is for use by physicians or practitioners furnishing telehealth services from a distant site. When billing telehealth services, distant site providers must bill with place of service code 02 and continue to bill modifier GT (via interactive audio and video telecommunication systems) or GQ (via asynchronous telecommunications system). Telehealth services not billed with the new place of service code 02 will be denied back to the provider. Please review Anthem’s Telehealth Services Professional Reimbursement Policy 0007 at this link: https://www11.anthem.com/provider/noapplication/f0/s0/t0/pw_g319057.pdf?refer=ahpprovider&state=wi for more information.

**WPS Response:** We do not require GT to be billed.
**Coverage of CPT 99483**

**Question:** Will your carrier be covering CPT 99483? If so, will the coverage have restrictions and/or a policy that we can reference for our providers to follow the appropriate guidelines?

**Question for:** Third Party Payer | Medicaid | Medicare

**Code:** 99483

**Setting:** Cognitive Assessment and Care Plan Services

**Providers:**

Submitted by: Carl Langhoff  
Marshfield Clinic  
Reimbursement Policy Analyst  
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**WEA Response:** At this time, we would pay based on all the requirements indicated in the code description. However, if we start to see abuse of the code we will re-visit our stance.

Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements:  
- Cognition-focused evaluation including a pertinent history and examination;  
- Medical decision making of moderate or high complexity;  
- Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity;  
- Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]);  
- Medication reconciliation and review for high-risk medications;  
- Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s);  
- Evaluation of safety (eg, home), including motor vehicle operation;  
- Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks;  
- Development, updating or revision, or review of an Advance Care Plan;  
- Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes

**Physicians Plus, Quartz Affiliate:** Yes, this will be covered as an office visit benefit.

**Security Health Plan:** CPT 99483 is a covered service, and we are working on a policy.
ANSWER: National Government Services, Inc. (Medicare): Currently Medicare uses the G-code, G0505 for assessment and care plan services for patients with cognitive impairment. This code was effective 1-1-2017 and an article was published at that time.

ForwardHealth: Please see the ForwardHealth interactive fee schedule for allowable procedure codes. Procedure code 99483 is non-covered.

Cigna: Not eligible for separate reimbursement

Anthem Response: Coverage is subject to the terms and conditions of the members benefit policy. Provides should call the telephone number on the back of the members identification card. From a reimbursement perspective according to Anthem Bundled Services and Supplies Policy 0008 at this link: https://www11.anthem.com/provider/noapplication/f0/s0/t0/pw_g330565.pdf?refer=ahpprovider&state=wi, patient care planning services are considered to be part of overall care responsibility including, but not limited to, advanced care planning, care coordination, care management, care planning oversight, education and training for patient self-management, medical home program, comprehensive care coordination and planning (initial and maintenance), physician care plan oversight, team conferences, etc. and are therefore not eligible for separate reimbursement.

WPS: We have no restrictions on coverage for this code
Non-Waiver Signed to Hold Responsible for Services

**Question:** Do you currently require a non-covered waiver to be signed in order to hold the member responsible for services that will be denied as non-covered or experimental/investigational? Would this waiver be required in all situations or only for services that require pre-authorization/pre-certification/notification? If a waiver is required, what information is required to be present on the document (i.e. DOS, CPTs, billed, amount, etc.)?

**Question for:** Third Party Payer

**Code:** Non-Covered Waiver

**Setting:** Member Responsibility

**Providers:**

**Submitted by:** Carl Langhoff

Marshfield Clinic

Reimbursement Policy Analyst

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**WEA Response:** If you want to ensure the patient/member has to pay for the service it is recommended. Any waiver must contain at a minimum the patient/member name, the service specifically along with the CPT/HCPCS or other appropriate code, the date of service and the anticipated amount the Participant is expected to be responsible for.

**Physicians Plus, Quartz Affiliate:** No, we would not require a non-covered waiver.

**Security Health Plan:** For participating providers, we do not require a signed waiver to bill the member. However, Security Health Plan indicates with their ANSI denial reasons the party that is responsible for the denied service, either provider or member. Participating providers are not allowed to bill a member for amounts denied to the provider.

**Cigna:** Yes, it is important to notify a patient when something is considered experimental or non-covered under their plan. There is a difference between, non-medically necessary and non-covered services. This varies from plan to plan and so it is wise to get a signed waiver stating they are responsible for those services. Yes, indicate what services are not covered and potential cost of each service.

There is verbiage in our Hospital contracts, stating that the hospital has notified the patient of that information and they have the patient sign a waiver stating this.

The Limitations on Billing Participants for Covered Services set forth in the first
Limitations On Billing Participants for Non Medically Necessary Services. Hospital shall not charge a Participant for a service that is not Medically Necessary unless, in advance of the provision of such service, Hospital has notified the Participant that the particular service will not be covered and the Participant acknowledges in writing that he or she shall be responsible for payment of charges for such service.

**Anthem Response:** Yes, a waiver is required in order to bill the member for non-covered or experimental/investigational services. The waiver should notify the member of the potential for the services to be non-covered, experimental/investigational, approximate cost, date of service and signed by the member. Providing this type of transparency to the member ensures an optimal experience for both the member and provider.

**WPS:** We do not require a waiver for members to sign. Medical policies are on line at [WWW.wpsic.com/provider\medical policies](http://WWW.wpsic.com/provider\medical policies). Updates to the policies are sent out via a provider newsletter quarterly.
MDPP Expanded Model

**Question:** With Medicare implementing the Medicare Diabetes Prevention Program (MDPP) expanded model, will you be allowing coverage for CDC approved diabetes prevention services?

**Question for:** Third Party Payer | Medicaid

**Code:** MDPP

**Setting:** Diabetes Prevention

**Providers:**

Submitted by: Carl Langhoff

Marshfield Clinic

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**WEA Response:** This is not something we have adopted at this time.

**Physicians Plus, Quartz Affiliate:** No benefit changes have been made at this time.

**Security Health Plan:** This service will not be covered for Commercial plans.

**ForwardHealth:** Medicaid is not in a position to reimburse this type of program at this time. In the future, Medicaid may be able to consider coverage of a similar model under a waiver or Chronic Disease prevention program. Providers will be notified of any coverage policy changes.

**Cigna:** Cigna has already implemented more Coverage for patients with Diabetes. At this time no policy stating we are implementing the CDC recommendations.

**Anthem Response:** For commercial Anthem members covered under an ACA compliant plan, Type 2 diabetes screen is covered without member cost share and CDC-recognized Diabetes Prevention programs are available for overweight or obese adults with abnormal blood glucose or who have abnormal CVD risk factors. In addition commercial members have access to our Condition Care Programs to help them manage chronic conditions such as diabetes. Here is a link to more information available on our public provider website:

https://www.anthem.com/wps/portal/ahpprovider?content_path=shared/noapplication/f0/s0/t0/pw_e183013.htm&state=in&rootLevel=1&label=ConditionCare

**WPS:** Is this for diabetic education? If so, then this would be covered.
Asst. Surgeon Modifier

**Question:** What assistant surgeon modifier (80,81,82,AS) do you require for:

1) MidLevel Provider (NP, PA) Assist
2) MD Assist

**Question for:** Third Party Payer | Medicaid | Medicare

**Code:** Surgical procedures

**Setting:** Surgical assist

**Providers:** MD/NP/PA

**Submitted by:** Leah Riesser

Monroe Clinic

Coding Coach

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**WEA Response:** we follow standard coding guidelines for surgical assist and would expect to have the claim coded as such.

**Physicians Plus, Quartz Affiliate:** We follow CMS guidelines regarding assistant surgeon modifiers

**Security Health Plan:** Mid-level provider (NP, PA) surgical assist should use modifier AS. MD surgical assist should use modifier 80, 81, or 82, according to the description of those modifiers

**ANSWER: National Government Services, Inc. (Medicare)**

The CMS IOM 100-04 Chapter 12 Section 20.4.3 includes the modifiers used for Assistant Surgery.

Assistant at surgery physician modifiers include 80, 81 and 82.

Modifier AS is used for a PA, NP or CNS when billing for assistant surgery.

**ForwardHealth:** Topic #578 – Co-surgeons/Assistant Surgeons, of your ForwardHealth Online Physician Handbook provides the definition of the accepted assistant surgeon modifiers for each.

**Cigna:** Yes see Cigna policy MAS

1) Midlevel Provider (NP,PA) assist- AS
2) MD Assist (89,81,82)
**Anthem Response:** Anthem would expect physicians assisting to bill with modifiers 80, 81 or 82 and non-physicians assisting to bill with modifier AS. For more information please see our Assistant Surgeon Service Reimbursement Policy 0009 at this link: https://www11.anthem.com/provider/noapplication/f0/s0/t0/pw_g313741.pdf?refer=ahpprovider&state=wi.

**WPS:** Mid-level assist’s we prefer modifier “AS”, MD assists can use either 80, 81 or 82
Interactive Complexity Charge

**Question:** If EMDR (Eye Movement Desensitization and Reprocessing) therapy modality is used in a psychotherapy session, will a charge of 90785 Interactive Complexity be covered in addition to the 90834 Psychotherapy, 45 minutes with patient charge for the session? Will it be covered with diagnoses other than a PTSD diagnosis?

**Question for:** Third Party Payer | Medicaid | Medicare

**Code:** 90785

**Setting:** Psychotherapy session

**Providers:** Behavioral Health provider

**Submitted by:** Leah Riesser

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**WEA Response:** Having done investigation, we believe this code is being misused and we will be addressing this in the near future. We will be looking at adding coverage limitation.

**Physicians Plus, Quartz Affiliate:** We cannot advise providers on coding/billing services but do not feel as though 90785 is the most appropriate code for EMDR.

**Security Health Plan:** We are not convinced CPT 90785 is the correct code for EMDR services. Diagnoses other than PTSD related issues would not be covered for EMDR.

**ANSWER: National Government Services, Inc. (Medicare)**

Yes, National Government Services LCD 33632 for Psychiatric Services, includes the following: The interactive complexity component code 90785 may be used in conjunction with codes for diagnostic psychiatric evaluation (90791, 90792) and psychotherapy (90832, 90834, 90837), psychotherapy when performed with an evaluation and management service (90833, 90836, 90838), and group psychotherapy (90853). There are a number of conditions listed in the LCD that can be covered for this code 90785.

**ForwardHealth:** ForwardHealth does not have published coverage policy guidelines for EMDR. Providers are expected to follow correct coding guidelines. Please refer to CPT definition of interactive complexity.

**Cigna:** Behavioral Health was not included in this question session. Will respond after the session

**Anthem Response:** Coverage is subject to the terms and conditions of the members benefit policy. Providers should call the telephone number on the back of the members identification card. From a
reimbursement perspective, CPT 90785 is add-on code to 90834 and is allowed separately. There are no edits today that would bundle this code. Providers need to follow the correct ICD-10 coding guidelines for reporting appropriate diagnosis.

**WPS:** These are covered services.
Pharmacy Students – G0463

**Question:** What supervision guidelines and documentation/attestation statements do you require for when pharmacy students and residents perform pharmacotherapy visits under direct supervision of a pharmacist and billed under general supervision of a physician? Medicare is billed as a facility only charge (G0463).

**Question for:** Medicare

**Code:** G0463

**Setting:** Pharmacotherapy visits under direct supervision of a pharmacist and billed under general supervision of a physician

**Providers:** PharmD billing under MD

**Submitted by:** Leah Riesser

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**ANSWER: National Government Services, Inc. (Medicare)**
Add-On

**Question:** Does your billing system accept the add-on CPT 95941 or will the claim process with HCPCS G0453 as the add-on code instead? These codes would be billed in conjunction with the base code per CPT guidance.

**Question for:** Third Party Payer | Medicaid | Medicare

**Code:** 95941 or G0453

**Setting:** Inpt/Outpt Hospital

**Providers:** MD

**Submitted by:** Leah Riesser

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**WEA Response:** These codes exclude set up time, time to record, and interpreting the baseline studies as well as removing the electrodes. Therefore, we would expect that those activities would not be included in the time tracking. Having said that, we currently cover both codes, however that is currently being reviewed.

**Physicians Plus, Quartz Affiliate:** Yes, we accept either code.

**Security Health Plan:** Either code is acceptable as an add-on.

**ANSWER: National Government Services, Inc. (Medicare)**

Medicare recognizes G0453 for Neurophysiology monitoring.

**ForwardHealth:** Please see the ForwardHealth interactive fee schedule for allowable procedure codes. Procedure code 95941 is allowable. Procedure code G0453 is non-covered.

**Cigna:** Response for coding this was not received in time for publication, will review and advise at conference or send separate after meeting

**Anthem Response:** Anthem will accept code 95941. For additional information please see Anthem’s Bundled Services and Supplies Policy 0008 at this link: [https://www11.anthem.com/provider/noapplication/f0/s0/t0/pw_g319035.pdf?refer=ahpprovider&state=wi](https://www11.anthem.com/provider/noapplication/f0/s0/t0/pw_g319035.pdf?refer=ahpprovider&state=wi). G0453 is listed in section two and indicates CPT 95737 is not reimbursed when submitted with 95940, 95941 or G0453.

**WPS:** Either code will be accepted as an appropriate add on code to the affiliated base codes
Midlevel Provider Supervision of Resident

**Question:** Can a midlevel provider (NP/PA) supervise a resident for surgical procedures performed in the hospital if this midlevel provider is listed as faculty in our residency program on the ACGME faculty list?

**Question for:** Medicare

**Code:** Surgical procedures

**Setting:** Inpatient/Outpatient Hospital

**Providers:** Mid-level (NP/PA)

**Submitted by:** Leah Riesser

  Monroe Clinic
  Coding Coach
  leah.riesser@monroeclinic.org | 608-324-1677

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**ANSWER:** National Government Services, Inc. (Medicare)

*(Waiting for response from other area)*
Therapy Modifiers

**Question:** Do you require therapy modifiers (GP, GN, GO) when billing for physical and occupational therapy services?

**Question for:** Third Party Payer

**Code:** Physical & Occupational Therapy

**Setting:**

**Providers:**

Submitted by: Monica Oas

SSM Health - Dean Medical Group
Billing & Reimbursement Analyst
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**WEA Response:** Yes, we do require the modifiers.

**Physicians Plus, Quartz Affiliate:** Yes

**Security Health Plan:** Yes, these therapy modifiers are required.

**Cigna:** No, these modifiers are not required, based on current policy information 3/18.

**Anthem Response:** Although, modifiers are not “required” for commercial members, they are requested to assist in the accurate determination of the service rendered. Anthem does require modifiers 96 (habilitative service) or 97 (rehabilitative service) for accurate service accumulation under commercial member benefits. Providers are reminded that since November 1, 2015, physical and occupational therapy service require authorization through OrthoNet. Here is a link to an FAQ document: [https://www11.anthem.com/provider/noapplication/f1/s0/t0/pw_e239517.pdf?refer=ahpprovider&state=wi](https://www11.anthem.com/provider/noapplication/f1/s0/t0/pw_e239517.pdf?refer=ahpprovider&state=wi)

**WPS:** these modifiers are not required when submitting physical therapy services.
Procedure while in Outpatient Status

Question: Patient undergoes a procedure (CPT 44125 for example) while in an outpatient (surgical day care) status. Procedure has a C status on OPPS Addendum B, meaning it is only payable as an Inpatient procedure. The next day, the patient is admitted to the hospital as an Inpatient and by rule, the facility bills the surgical service as inpatient, since it was within the 3 days preceding the IP admission. The physician however, must bill a POS for CPT 44125 that reflects the patient's status on the day of the procedure - POS 22. According to CMS, should the physician’s claim for CPT 44125 with POS 22 be denied payment based on the OPPS status indicator?

Question for: Medicare

Code: All procedures with C status in OPPS Addendum B

Setting:

Providers: Physician/professional claim

Submitted by: Monica Vandenheuvel

SSM Health - Dean Medical Group
Billing & Reimbursement Analyst
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ANSWER: National Government Services, Inc. (Medicare)

No, the physicians claim should not deny based on place of service 22.
Procedure Coverage

**Question:** Do you plan to cover this procedure? Question was last posed in July 2017; are there any updates or plans to cover in 2018?

**Question for:** Third Party Payer | Medicaid

**Code:** 0474T

**Setting:**

**Providers:**

**Submitted by:** Monica Vandenheuvel

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**WEA Response:** no, we do not cover this code. We generally do not cover new/emerging technology category III codes.

**Physicians Plus, Quartz Affiliate:** Authorization is required for payment consideration.

**Security Health Plan:** This code is still considered experimental/investigational and is noncovered.

**ForwardHealth:** This is a non-covered service per ForwardHealth Max Fee schedule.

**Cigna:** No changes, not covered

**Anthem Response:** This code was added to Medical Policy SURG.0013 at this link: [https://www.anthem.com/medicalpolicies/policies/mp_pw_b088812.htm](https://www.anthem.com/medicalpolicies/policies/mp_pw_b088812.htm) effective November 1, 2017. Coverage is subject to medical necessity criteria detailed within the policy.

**WPS:** Prior authorization is required
ICD-10 Code Z03.6

**Question:** ICD-10 code Z03.6 is appropriately appended to CPT 95076 for patients who believe they have a penicillin allergy, but for whom there is no record to be found of this allergic reaction, and for whom no current signs/symptoms of the allergy exist (due to overall avoidance of penicillin). Upon penicillin challenge testing, it is confirmed that no such allergy exists and penicillin is chosen as the most appropriate antibiotic for the patient. Why are these challenge tests being denied? See for example ICN #2217242548250.â€

**Question for:** Medicare

**Code:** 95076

**Setting:** Penicillin Allergy Testing

**Providers:**

**Submitted by:** Monica Vandenheuvel

SSM Health - Dean Medical Group

Billing & Reimbursement Analyst

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**ANSWER: National Government Services, Inc. (Medicare)**

The claim example provided denied appropriately. The diagnosis billed, Z03.6 is a routine screening diagnosis. Medicare does not cover routine screening services.
Edits to Deny Codes Billed with Laterality Modifiers

**Question:** Do you have any edits in your system to deny Unlisted CPT codes billed with laterality modifiers (RT, LT, 50)?

**Question for:** Third Party Payer | Medicaid

**Code:** Unlisted CPT Codes

**Setting:**

**Providers:**

Submitted by: Monica Vandenheuvel

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**WEA Response:** Yes, we do have edits surrounding this type of billing.

**Physicians Plus, Quartz Affiliate:** No, we do not have any edits in our system to deny unlisted codes when billed with laterality modifiers, but all unlisted codes are reviewed by coding department for accuracy.

**Security Health Plan:** It depends on the CPT code. For example, CPT 24999 does not deny if a laterality modifier is billed. However, CPT 97799 does have an edit to deny for laterality modifier. Specifics would be needed to completely answer this question.

**ForwardHealth:** Providers should follow the guidelines found in Topic #643 – Unlisted Procedure Codes of your ForwardHealth Online Physician Handbook.

**Cigna:** Yes, edit in place for modality modifier as well as unlisted code policy

**Anthem Response:** Anthem’s Modifier Rules Professional Reimbursement Policy 0017 can be found at this link:
https://www11.anthem.com/provider/noapplication/f0/s0/t0/pw_g322754.pdf?refer=ahpprovider&state=wi and cite that our claim editing system identifies if a modifier is inappropriately used with a procedure code. When an invalid modifier to procedure code combination is detected, the line item will be denied, with a request that the correct code and modifier combination be resubmitted. We validates that the following modifiers are appropriately used with procedure codes: 22, 23, 24, 25, 26, 27, 50, 52, 53, 54, 55, 56, 57, 59, 62, 63, 73, 74, 76, 77, 78, 79, 80, 81, 82, 91, 92, 95, AA, AD, AS, BP, BR, CT, E1-E4, EX, F1-F9, FA, KC, KR, LC, LD, LM, LT, MS, NR, NU, P3, P4, P5, QK, QX, QY, QZ, RA, RB, RC, RI, RR, RT, T1-T9, TA, TC, UE, UE, XP, XS, and XU.

**WPS:** All unlisted codes are set to stop in the system for a manual review with or without modifiers
J2310 Coverage Administered Intranasally

**Question:** Please advise if you cover J2310 administered via intranasal route for the purpose of detoxing patients that have an Opioid overdose. Also what would be the appropriate CPT code to bill for the intranasal administration charge?

**Question for:** Third Party Payer | Medicaid | Medicare

**Code:** J3210 - Naloxone administered via intranasal route

**Setting:** Clinic and Outpatient Hospital

**Providers:** MD, Midlevels

**Submitted by:** Pam Steve

  Ministry Health System
  System Supervisor
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**WEA Response:** Yes, we cover J2310 based on the member’s policy. 90473 is for the initial and 90474 is for each additional.

**Physicians Plus, Quartz Affiliate:** We cannot advise on what CPT code to bill for the administration. J2310 does not require an auth and is a covered code.

**Security Health Plan:** We do not feel that J2310 is the appropriate code for intranasal administration of Naloxone, as J2310 is an injection code. Unfortunately, we cannot tell providers what to bill.

**ANSWER: National Government Services, Inc. (Medicare)**

No, Medicare does not cover or pay for J2310.

**ForwardHealth:** ForwardHealth does cover Naloxone J2310. Please see the ForwardHealth Max Fee schedule for reimbursement information.

**Cigna:** Unable to locate any policy regarding this and would need to review and return response at a later date.

**Anthem Response:** J2310 is a covered code but is listed as an injection. Provider will need to bill in accordance with the reporting guidelines and instructions contained in the American Medical Association (AMA) CPT codebook, “CPT Assistant,” HCPCS, ASA Relative Value Guide, and ICD-10-CM publications. At this time there does not appear to be an intranasal administration code listed for this drug. Unlisted drug codes must be submitted with the applicable NDC number and description. Anthem cannot advise on how or what codes to bill. At this time there does not appear to be an intranasal administration code listed for this drug.

**WPS:** this is a covered service and pre-auth is not required