Anthem Blue Cross and Blue Shield reimbursement policies

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Anthem Blue Cross and Blue Shield (Anthem) reimbursement policies for Ohio Medicaid became effective February 1, 2023 and are located on the Anthem provider website.

For dates of service (DOS) that span prior to February 1, 2023, the legacy Paramount Medicaid policies will apply for members who are transitioning to Anthem for their Medicaid coverage. For any claim whose DOS starts prior to and ends after February 1, 2023, providers will continue to use Paramount Medicaid policies. The legacy Paramount reimbursement policies can be found at **https://www.paramounthealthcare.com/services/providers/reimbursement-policies**.

Anthem reimbursement policies apply to providers who serve members enrolled in Anthem with dates of service on or after February 1, 2023, and are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations. To view the Anthem reimbursement policies for Ohio Medicaid, visit the provider self-service website at **https://providers.anthem.com/oh**.

What does this mean to me?

Refer to the reimbursement policy websites, your respective provider manual, and/or your respective provider contract as a guide for reimbursement criteria. Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member’s benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member’s state of residence. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions.

Reimbursement policies undergo reviews for updates to state contracts, rules, and requirements, as well as federal and CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to an Anthem business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policy at **https://providers.anthem.com/oh**.

Code and clinical editing

Anthem applies code and clinical editing guidelines to evaluate claims for accuracy and adherence to accepted national industry standards and plan benefits. We use sophisticated software products to ensure compliance with standard code edits and rules. These products increase consistency of payment for providers by ensuring correct coding and billing practices. Editing sources include but are not limited to CMS National Correct Coding Initiative, *Medical Policies*, and *Clinical Utilization Management Guidelines*. Anthem is committed to working with you to ensure timely processing and payment of claims.

What if I need assistance?

The complete set of policies are available at **https://providers.anthem.com/oh**. If you have questions, visit the provider self-service website. You may also contact your Anthem Provider Experience consultant.

If you have legacy Paramount reimbursement policy questions related to claims prior to and/or spanning past February 1, 2023, contact a Paramount Provider Services representative or call **419-887-2535** or **800-891-2542**.

Reimbursement policies

Refer to the complete list of reimbursement policies on the reimbursement policy website, your provider manual, and/or your provider contract. These policies apply unless provider, federal, or CMS contracts and/or requirements indicate otherwise.

Policy topic	Category
Abortion (Termination of Pregnancy)	Surgery
Assistant at Surgery Guidelines (Modifier 80/81/82/AS)	Coding
Claim Requiring Additional Documentation	Administration
Claim Submission — Required Information for Facilities	Administration
Claim Submission — Required Information Professional	Administration
Claims Timely Filing	Administration
Claims with Charge Discrepancies	Administration
Code and Clinical Editing Guidelines	Administration
Consultations	Evaluation and Mangement
Corrected Claims	Administration
Diagnoses Used for DRG Computation	Coding
Distinct Procedural Services (Modifiers 59, XE, XP, XS, XU)	Coding
DME Modifiers for New, Rented, and Used Equipment	DME and Supplies
Documentation Standards for Episodes of Care	Administration
DRG Inpatient Facility Transfers	Facilities
DRG Newborn Inpatient Stays	Facilities
Drug Screen Testing	Laboratory
Drugs and Injectable Limits	Drugs
Duplicate Services on the Same Date of Service	Administration
Durable Medical Equipment (Rent to Purchase)	DME and Supplies
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	Prevention
Eligible Billed Charges	Administration
Emergency Services: Non-Participating Providers and Facilities	Administration
Facility Take-Home DME and Medical Supplies	DME and Supplies
Global Surgical Package	Surgery
Hysterectomy	Surgery
Inpatient Readmissions	Facilities
Locum Tenens Physicians	Administration
Maternity Services	Surgery
Maximum Units Per Day	Administration
Medical Recalls	Administration
Modifier 24: Unrelated E&M Service	Coding
Modifier 25: Significant, Separately Identifiable E&M Service by the Same Physician on the Same Day of the Procedure or Other Service	Coding
Modifier 26 and TC: Professional and Technical Component	Coding

Modifier 62: Co-Surgeons	Coding
Modifier 63: Procedure on Infants less than 4kg	Coding
Modifier 78: Return to OR for Related Procedure during the Postoperative Period	Coding
Modifier 90: Reference (Outside) Laboratory and Pass-Through Billing	Coding
Modifier 91: Repeat Clinical Diagnostic Laboratory Test	Coding
Modifier LT/RT: Left Side/Right Side Procedures	Coding
Modifier Usage	Coding
Multiple and Bilateral Surgery: Professional and Facility Reimbursement	Coding
Multiple Delivery Services	Surgery
Multiple Procedure Payment Reduction	Medicine
Multiple Radiology Payment Reduction	Radiology
Nurse Practitioner and Physician Assistant Services	Administration
Portable/Mobile/Handheld Radiology	Radiology
Preadmission Services for Inpatient Stays	Facilities
Preventable Adverse Events	Administration
Preventive Medicine and Sick Visits on Same Day	Evaluation and Management
Professional Anesthesia Services	Anesthesia
Prosthetics and Orthotics Devices	Prosthetics and Orthotics
Reimbursement for Items under Warranty	Administration
Reimbursement for Reduced and Discontinued Services	Coding
Requirements for Documentation of Proof of Timely Filing	Administration
Reimbursement of Sanctioned Providers	Administration
Robotic Assisted Surgery	Surgery
Scope of Practice	Administration
Sexually Transmitted Infections — Testing	Laboratory
Sterilization	Surgery
Transportation Services: Ambulance and Non-Emergent Transport	Transportation
Unlisted, Unspecified, or Miscellaneous Codes	Coding
Vaccines for Children (VFC) Program	Prevention

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