Anthem Blue Cross and Blue Shield
Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

March 2017

Update to previous communication: Adding Modifier 52 to the routine anatomic evaluation billing code

Summary:

In our continuing efforts to improve pregnancy outcomes and prevent preterm births, Anthem Blue Cross and Blue Shield previously communicated with you our endorsement of the American College of Obstetricians and Gynecologists and Society for Maternal Fetal Medicine guidelines on cervical length (CL) screening and progesterone treatment.

We continue to encourage you to obtain a CL measurement during prenatal routine anatomic evaluation ultrasounds. For claims submitted on or after [effective date], if a vaginal approach is necessary in addition to an abdominal scan to obtain this measurement, it is required that you append Modifier 52 to the transvaginal ultrasound.

Why is this change necessary?

Modifier 52:

- Indicates procedures for which services performed are less than usually required.
- Reduces reimbursement to the lower of the billed charges or 50% of the applicable fee schedule or contracted/negotiated rate.

What is the impact of this change?

When a routine anatomic evaluation ultrasound (76801, 76802, 76805 or 76810) and a transvaginal ultrasound (76817) are billed on the same day by the same provider, the transvaginal ultrasound is considered a reduced service and must be appended with Modifier 52 to ensure appropriate reimbursement.

The incomplete procedure will be paid at 50% of the applicable fee schedule, and the complete procedure will be paid at the full applicable fee schedule.

When two prenatal ultrasound procedures are billed on the same day by the same provider and neither billing CPT code is appended by Modifier 52, one of the ultrasound procedures will be denied for incorrect coding. Should your claim be denied, you may resubmit the claim with the appropriate modifier or appeal.

What if I need assistance?

If you have questions about this communication, received this fax in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at **1-800-454-3730**.

This is an update about information in the provider manual. For access to the latest manual, go online to **www.anthem.com/inmedicaiddoc.**

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Anthem Blue Cross and Blue Shield
Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

Anthem. BlueCross BlueShield

August 20, 2015

Dear Provider:

In our continuing efforts to improve pregnancy outcomes and prevent preterm birth (PTB), we are announcing our endorsement of the American College of Obstetricians and Gynecologists (ACOG) and Society for Maternal Fetal Medicine (SMFM) guidelines on cervical length (CL) screening and progesterone treatment.[1]

As you know, the risk factor most consistently predictive of PTB is a prior preterm birth.[2] Women with this risk factor are currently treated with alpha-hydroxyprogesterone caproate (17P) by intramuscular injection weekly from 16 to 36 weeks; however, less than 10% of spontaneous PTB occurs in women with a prior history.

We have a tremendous opportunity to address this by screening CL and treating with progesterone. Shortened CL before 24 weeks is now recognized to be a second strongly predictive risk factor for PTB in singleton pregnancies.[3] Using this evidence-based strategy, we can improve our efforts by identifying and treating at risk women who might not be otherwise identified.

ACOG and SMFM have collaborated to promote an algorithm to aid in this endeavor. Anthem Blue Cross and Blue Shield endorses this strategy of CL screening and treating with progesterone.[4] We support universal CL screening at 18 to 24 weeks.[5] CL screening by ultrasound is considered the gold standard and makes other measuring methods and devices medically unnecessary.[6]

Attached is the algorithm. We encourage you to obtain a CL measurement with your patient's 18- to 24-week ultrasound as shown on the algorithm. If, in addition to an abdominal scan, a vaginal approach is necessary to obtain this measurement, please add modifier 52 to the vaginal ultrasound billing code. Diagnosis codes such as V28.82 and V23.41 are the most appropriate. We believe this will help you continue to provide high quality, evidence-based prenatal care to your patients.[7]

We thank you for your care of our members.

Sincerely,

Dr. Virginia San Miguel, MD
Medical Director
Maternal Child Services

Dr. Kimberly Roop, MD, MBA
Managing Medical Director
Anthem Hoosier Healthwise, Hoosier Care Connect and Healthy Indiana Plan

Enclosure: Short cervix algorithm

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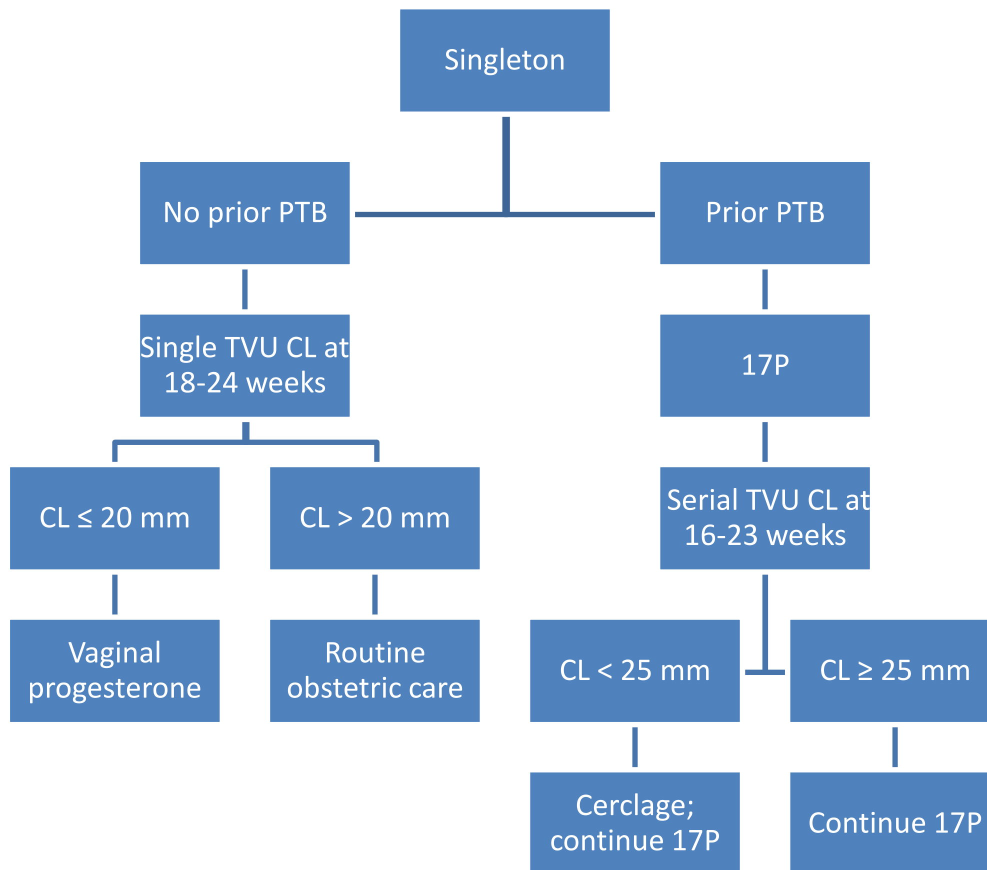

The above algorithm is based on the ACOG recommendation referenced in footnote 1.

1. Society for Maternal-Fetal Medicine Publications Committee with the assistance of Vincenzo Berghella, MD, Progesterone and preterm birth prevention: translating clinical trials data into clinical practice, Am J Obstet Gynecol 2012;206:376-386.
2. J.D Iams, R.L. Goldenberg, P.J. Meis, et al., The length of the cervix and the risk of spontaneous premature delivery, N Engl J Med 1996;334:567-572.
3. S.S. Hassan, R. Romero, D. Vidyadhari, et al., Vaginal progesterone reduces the rate of preterm birth in women with a sonographic short cervix: a multi-center, randomized, double-blind, placebo-controlled study, Ultrasound Obstet Gynecol 2011;38:18-31.
4. S. Campbell, Universal cervical length screening and vaginal progesterone prevents early preterm births, reduces neonatal morbidity and is cost saving: doing nothing is no longer an option, Ultrasound Obstet Gynecol 2011;38:1-9.
5. ACOG/SMFM letter to Secretary Burwell, 2014.
6. American Institute of Ultrasound in Medicine, AIUM practice guideline for the performance of obstetric ultrasound examinations, J Ultrasound Med 2013;32:1083-1101. doi:10.7863/ultra.32.6.1083.
7. R. Romero, K. Nicolaides, A. Conde-Agudelo, et al., Vaginal progesterone in women with an asymptomatic sonographic short cervix in the midtrimester decreases preterm delivery and neonatal morbidity: a systematic review and meta-analysis of individual patient data, Am J Obstet Gynecol 2012;206:124.el-19.