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

July 2019

G18 denial code update

EOP denial code G18 — **disallow not allowed under contract —** maps to *HIPAA* remark code C0-256 — **service not payable per managed care contract** — and is used to advise the provider that the service billed cannot be found on the fee schedule associated with their contract agreement ID.

This denial may post for several reasons:

- Several procedure codes are not listed on the state's fee schedule. Without a coverage indicator, a noncovered denial cannot be generated. When the claim is compared to the provider's fee schedule associated with the agreement ID, the code is not found and is considered **not allowed under contract**.
- The procedure code requires a modifier for pricing. This applies to codes that have a specific rate tied to the procedure code/modifier combination, such as NU, RR, TC, 26, etc. It does not apply to codes with modifiers that adjust the rate based on a percentage, such as 50, 51, QX, etc. If the procedure code is billed without a required modifier, the system cannot find a row on the fee schedule that matches, thus, making it not allowed under the contract. There are other procedure code/modifier pricing requirements that would also fall into this category.
- The provider is contracted to provide only certain services. If a hospital provider billed for professional services on the *CMS-1500* claim form and the hospital was only contracted as a facility, their agreement ID will does not have pricing established for professional services. Some hospitals are contracted as both facilities and groups because they use the same NPI and TIN to report services for the hospital and associated physician groups. In some cases, the system may select the incorrect Anthem Blue Cross and Blue Shield (Anthem) provider ID record and process a facility claim under a group ID, or vice versa. This can result in a G18 denial as well.
- A facility provider has billed an invalid revenue code/procedure code combination. This includes situations in which the revenue code is restricted, requires procedure code with pricing, is not covered in an outpatient setting, is not separately reimbursed or is only allowed with a specific list of procedure codes.

If you receive a G18/CO-256 denial:

1. Review the Indiana Health Coverage Programs (IHCP) *Professional Fee Schedule* and *Outpatient Fee Schedule,* available at **www.indianamedicaid.com**.
    a. If the procedure code is not found, the service is not covered and will not be reimbursed.
    b. If the procedure requires a specified pricing-associated modifier such as NU, RR, etc., is there a row on the fee schedule that matches the procedure code/modifier

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.
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combination (or lack thereof) billed on the claim? If a modifier is required but was not included on the original claim or if the service meets the criteria for coverage with one of the pricing-associated modifiers, submit a corrected claim.

c. For facility claims, check to ensure that a revenue code and procedure code match exists. Additionally, review any revenue code tabs for specific procedure code combination requirements.

2. Review your provider contract(s) to determine if there are any code restrictions or limitations.
    a. If it appears the claim was processed under an incorrect Anthem provider ID record (group vs. facility or facility vs. group), you may contact Provider Services or submit a claim dispute form to have the claim reviewed and, if applicable, reprocessed under the correct provider ID.
    b. If the service being billed is outside the terms on the provider's contract, it will not be reimbursed. You may contact your provider contracting specialist to discuss options for having the service amended into your contract.
3. If none of the above identify the issue and you believe the denial is incorrect, contact Provider Services for additional assistance.

If you have any questions, please contact Provider Services:

- Hoosier Healthwise: **1-866-408-6132**
- Healthy Indiana Plan: **1-844-533-1995**
- Hoosier Care Connect: **1-844-284-1798**