

**BlueCross BlueShield of Tennessee**  
**Commercial Reimbursement Rule Indicators and RBRVS Relative Value Units (RVUs)**

**CODE**

CPT™ or HCPCS procedure code.

**MOD**

CPT™ or HCPCS modifier. This field will contain the following: blank, 26 for professional component, TC for technical component, or 53 to indicate a procedure that was started but discontinued. When modifier 53 is billed, reimbursement may be subject to review and priced by individual consideration.

**STATUS CODE**

Status code. BlueCross BlueShield of Tennessee will utilize Medicare status codes but may define them in a slightly different way. See the Exhibit A for BlueCross BlueShield of Tennessee status code explanations.

**PCTC IND**

The indicators in this field provide reimbursement guidelines on technical, professional or global services.

The indicators are as follows:

0 = Physician Service Codes--Identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The RVUs include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.

1 = Diagnostic Tests for Radiology Services--Identifies codes that describe diagnostic tests. Examples are pulmonary function tests or therapeutic radiology procedures, e.g., radiation therapy. These codes have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier include values for physician work, practice expense, and malpractice expense.

2 = Professional Component Only Codes--This indicator identifies stand-alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is **93010--Electrocardiogram; Interpretation and Report**. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.

3 = Technical Component Only Codes--This indicator identifies stand- alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic test only. An example of a technical component only code is **93005--Electrocardiogram; Tracing Only, without interpretation and report**. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be

used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only.

4 = Global Test Only Codes--This indicator identifies stand-alone codes that describe selected diagnostic tests for which there are associated codes that describe (a) the professional component of the test only, and (b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined. There are a few instances where the RVUs for the technical and professional do not equal the sum of the global procedure.

5 = Incident To Codes--This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct personal supervision. Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.

6 = Laboratory Physician Interpretation Codes--This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense, and malpractice expense.

7 = Physical therapy service, for which payment may not be made--Payment may not be made if the service is provided to either a patient in a hospital outpatient department or to an inpatient of the hospital by an independently practicing physical or occupational therapist.

8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies to code **85060**.

9 = Not Applicable--Concept of a professional/technical component does not apply.

### **GLOBAL DAYS**

Global period assigned to a procedure. This includes the routine preoperative history and physical including the hospital admission, the operative procedure and all care related to the surgical procedure.

The following are the indicators applicable to global days:

000 = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.

010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10 day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable.

090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount.

MMM = Maternity codes; usual global period does not apply.

XXX = The global concept does not apply to the code.

YYY = The carrier is to determine whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing.

ZZZ = The code is related to another service and is always included in the global period of the other service.

Refer to the BlueCross BlueShield of Tennessee Reimbursement Rules for Global Periods for additional information.

### **PRE OP**

Percentage for preoperative management portion of global package. For example, on procedure code 31294, the Pre Op column shows as 0.10 in the National Physician Fee Schedule Relative Value Fee Schedule. This means BlueCross BlueShield of Tennessee would pay the lesser of covered charges or 10% of the base allowable for this procedure for preoperative management services only. Refer to the BlueCross BlueShield of Tennessee Reimbursement Rules for Pre-operative Management Only, Surgical Care Only, and Post-operative Management Only for additional information.

### **INTRA OP**

Percentage for operative (surgical care only) portion of global package. For example, on procedure code 31294, the Intra Op column shows as 0.80 in the National Physician Fee Schedule Relative Value Fee Schedule. This means BlueCross BlueShield of Tennessee would allow the lesser of covered charges or 80% of the base allowable for this procedure for operative services only.

Refer to the BlueCross BlueShield of Tennessee Reimbursement Rules for Pre-operative Management Only, Surgical Care Only, and Post-operative Management Only for additional information.

### **POST OP**

Percentage for postoperative management portion of global package. For example, on procedure code 31294, the Pre Op column shows as 0.10 in the National Physician Fee Schedule Relative Value File. This means BlueCross BlueShield of Tennessee would allow the lesser of covered charges or 10% of the base allowable for this procedure for postoperative management services only.

Refer to the BlueCross BlueShield of Tennessee Reimbursement Rules for Pre-operative Management Only, Surgical Care Only, and Post-operative Management Only for additional information.

### **MULT PROC**

Multiple procedure indicator.

Refer to the BlueCross BlueShield of Tennessee Reimbursement Rules for Multiple Procedures for additional information.

### **BILAT SURG**

Bilateral procedure indicator.

Refer to the BlueCross BlueShield of Tennessee Reimbursement Rules for Bilateral Procedures for

additional information.

**ASST SURG**

The following indicators will be used to determine when a procedure is eligible for an assistant at surgery from a medical appropriateness perspective for BlueCross BlueShield of Tennessee members:

- 0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.
- 1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.
- 2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.
- 9 = Concept does not apply.

Refer to the BlueCross BlueShield of Tennessee Reimbursement Rules for Assistant at Surgery Services for details regarding reimbursement.

**CO-SURG**

The following indicators will be used to determine when a procedure is eligible for co-surgery (i.e. procedures performed by two surgeons) from a medical appropriateness perspective for BlueCross BlueShield of Tennessee members:

- 0 = Co-surgeons not permitted for this procedure.
- 1 = Co-surgeons could be paid, though supporting documentation is required to establish the medical necessity of two surgeons for the procedure.
- 2 = Co-surgeons permitted and no documentation required if the two-specialty requirement is met.
- 9 = Concept does not apply.

Refer to the BlueCross BlueShield of Tennessee Reimbursement Rules for Procedures Performed by Two Surgeons for details regarding reimbursement.

**WORK RVU with Adjustor**

Relative Value Unit for the physician work for the service.

Refer to the BlueCross BlueShield of Tennessee Reimbursement Rules for Resource Based Relative Value Scale (RBRVS) Reimbursement Methodology for details regarding Work RVUs.

**FULLY IMPLEMENTED NON-FACILITY PE RVU**

Relative Value Unit (RVU) for the practice expense for the non-facility setting.

Refer to the BlueCross BlueShield of Tennessee Reimbursement Rules for Resource Based Relative Value Scale (RBRVS) Reimbursement Methodology for details regarding Practice Expense RVUs.

**FULLY IMPLEMENTED FACILITY PE RVU**

Relative Value Unit (RVU) for the practice expense for the facility setting.

Refer to the BlueCross BlueShield of Tennessee Reimbursement Rules for Resource Based Relative Value Scale (RBRVS) Reimbursement Methodology for details regarding Practice Expense RVUs.

**MP RVU**

Relative Value Unit for malpractice expense.

Refer to the BlueCross BlueShield of Tennessee Reimbursement Rules for Resource Based Relative Value Scale (RBRVS) Reimbursement Methodology for details regarding Malpractice RVUs.

**FULLY IMPLEMENTED NON-FACILITY TOTAL**

Sum of work, non-facility practice expense and malpractice expense RVUs.

**FULLY IMPLEMENTED FACILITY TOTAL**

Sum of work, facility practice expense and malpractice expense RVUs.

**ROUNDED TOTAL NON-FACILITY RVU AND GPCI COMPONENT**

Rounded sum of the work, non-facility practice expense and malpractice expense components of the RBRVS calculation.

Refer to the BlueCross BlueShield of Tennessee Reimbursement Rules for Resource Based Relative Value Scale (RBRVS) Reimbursement Methodology for details regarding the RBRVS formula.

**ROUNDED TOTAL FACILITY RVU AND GPCI COMPONENT**

Rounded sum of the work, facility practice expense and malpractice expense components of the RBRVS calculation.

Refer to the BlueCross BlueShield of Tennessee Reimbursement Rules for Resource Based Relative Value Scale (RBRVS) Reimbursement Methodology for details regarding the RBRVS formula.

**EXHIBIT A**

Status codes indicate the payment methodology that applies to a code and whether it is separately payable if the service is covered. These codes are listed on the National Physician Fee Schedule Relative Value File located at [www.cms.gov](http://www.cms.gov).

BlueCross BlueShield of Tennessee will use the same codes as Medicare but may use them in a different way as described below.

Status Code	Description Per the Medicare National Physician Fee Schedule Relative Value File	Methodology to be Used by BLUECROSS BLUESHIELD OF TENNESSEE
A	Active code	The maximum allowable will be based on the published RVUs, GPCIs for Tennessee, and the contracted conversion factors.
B	Bundled code	Reimbursement for the code will be bundled to the service to which it is incident regardless of the location of service unless otherwise stated per the BlueCross BlueShield of Tennessee Reimbursement Rules for Bundled Services Regardless of the Location of Service.
C	Carrier-priced code	The maximum allowable for codes without published RVUs per the Medicare National Physician Fee Schedule Relative Value File will be based on a reasonable allowable as determined by BlueCross BlueShield of Tennessee. (*See Methods at bottom of chart)
D	Deleted code	Codes will be deleted in accordance with the BlueCross BlueShield of Tennessee Policies for CDT, CPT™, and HCPCS Code Updates. These policies are available in the BlueCross BlueShield of Tennessee Provider Administration Manuals.
E	Excluded from the physician fee schedule by Medicare regulation	The maximum allowable for codes without published RVUs per the Medicare National Physician Fee Schedule Relative Value File will be based on a reasonable allowable as determined by BlueCross BlueShield of Tennessee (*See Methods at bottom of chart)
F	Deleted/discontinued code	Codes will be deleted in accordance with the BlueCross BlueShield of Tennessee Policies for CDT, CPT™, and HCPCS Code Updates. These policies are available in the BlueCross BlueShield of Tennessee Provider Administration Manuals.
G	Code not valid for Medicare purposes. Medicare does not recognize codes assigned this status. Medicare uses another code for reporting of, and payment for, these services.	When appropriate, the maximum allowable will be based on the alternate code recognized by Medicare. When use of the pricing for Medicare's alternate code is not appropriate, the maximum allowable for the code will be based on a reasonable allowable as determined by BlueCross BlueShield of Tennessee. (*See Method at bottom of chart)
H	Deleted modifier. Either the TC (i.e. technical component) or modifier 26 (i.e. professional component) for the code has been deleted.	The TC or 26 modifier will be deactivated for the code in accordance with the BlueCross BlueShield of Tennessee Policy for Quarterly Reimbursement Updates.

Status Code	Description Per the Medicare National Physician Fee Schedule Relative Value File	Methodology to be Used by BLUECROSS BLUESHIELD OF TENNESSEE
I	Code not valid for Medicare purposes. Medicare does not recognize codes assigned this status. Medicare uses another code for reporting of, and payment for, these services. Code not subject to a 90-day grace period under Medicare.	When appropriate, the maximum allowable will be based on the alternate code recognized by Medicare. When use of the pricing for Medicare's alternate code is not appropriate, the maximum allowable for the code will be based on a reasonable allowable as determined by BlueCross BlueShield of Tennessee. (*See Methods at bottom of chart)
J	Anesthesia Services. There are no RVUs and no payment amounts for these codes. The intent of this value is to facilitate the identification of anesthesia services.	RBRVS reimbursement methodology does not apply to anesthesia administration. These services are reimbursed based on Reimbursement Policy for Anesthesia Administration by an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) and Reimbursement Policy for Administration of Regional or General Anesthesia Provided by a Surgeon.
M	Measurement codes, used for reporting purposes only.	BlueCross BlueShield of Tennessee considers codes published by Medicare with a Status Code "M" as bundled to the service to which they are incident. The maximum allowable for these codes is \$0.00 even when billed alone.
N	Non-covered service. Code is non-covered under Medicare. If RVUs are shown, they are not used for Medicare payment purposes.	When RVUs are published per the Medicare National Physician Fee Schedule Relative Value File, the maximum allowable will be based on published RVUs, GPCIs for Tennessee, and the contracted conversion factors subject to provisions of BCBST Reimbursement Policy. When RVUs are not published per the Medicare National Physician's Fee Schedule Relative Value File, the maximum allowable for the code will be based on a reasonable allowable as determined by BlueCross BlueShield of Tennessee. (*See Methods at bottom of chart)
P	Bundled code	Reimbursement for the code will be bundled to the service to which it is incident when the location of service is the physician's office unless otherwise stated on the BlueCross BlueShield of Tennessee Reimbursement Rules for Bundled Services When the Location of Service is the Physician's Office.
R	Restricted coverage. Special Medicare coverage instructions apply.	When RVUs are published per the Medicare National Physician Fee Schedule Relative Value File, the maximum allowable will be based on published RVUs, GPCIs for Tennessee, and the contracted conversion factors. When RVUs are not published per the Medicare National Physician's Fee Schedule Relative Value File, the maximum allowable for the code will be based on a reasonable allowable as determined by BlueCross BlueShield of Tennessee. (*See Methods at bottom of chart).

Status Code	Description Per the Medicare National Physician Fee Schedule Relative Value File	Methodology to be Used by BLUECROSS BLUESHIELD OF TENNESSEE
T	Injections. There are RVUs for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.	The maximum allowable will be based on the published RVUs, GPCIs for Tennessee, and the contracted conversion factors.
X	Exclusion by law for Medicare. These items represent an item of service that is not within the definition of physician services for Medicare physician fee schedule payment purposes. No RVUs are shown for these codes, and no payment may be made under the physician fee schedule for Medicare. Examples include ambulance and clinical diagnostic laboratory services.	The maximum allowable for codes without published RVUs per the Medicare National Physician Fee Schedule Relative Value File will be based on a reasonable allowable as determined by BlueCross BlueShield of Tennessee. (*See Methods at bottom of chart)
<p><b><u>*Methods to Determine Reimbursement when No Published RVU</u></b></p>		<p>Methods used by BlueCross BlueShield of Tennessee to determine reasonable allowable when no published RVU is available include, but are not limited to the following:</p> <ul style="list-style-type: none"> <li>• BlueCross BlueShield of Tennessee Reimbursement Policies and Procedures</li> <li>• Cigna Part B Medicare (Tennessee)</li> <li>• Medicare Clinical Laboratory Fee Schedule (Tennessee)</li> <li>• Medicare Region C Durable Medical Equipment Regional Carrier (DMERC) Fee Schedule for Tennessee</li> <li>• Ingenix (formerly St. Anthony's) Resource Based Relative Value Scale (RBRVS)</li> <li>• Manufacturer/supplier's invoice</li> <li>• Manufacturer name, product name, product number, and quantity</li> <li>• Name of the drug, National Drug Code (NDC), dosage and number of units</li> <li>• Based on fees for similar procedures in terms of time, skill, supplies, equipment, etc.</li> </ul>

<b>Notes</b>
Presence of a fee on the Maximum Allowable Fee Schedule is not a guarantee the procedure service or item will be eligible for reimbursement. Final reimbursement determinations are based on several factors, including but not limited to, member eligibility on the date of service, medical appropriateness, code edits, applicable member co-payments, coinsurance, deductibles, benefit plan exclusions/limitations, authorization/referral requirements and medical policy/coverage decisions.
Codes are subject to BlueCross BlueShield of Tennessee code editing (e.g., bundling/unbundling edits)
Maximum allowables are subject to be updated per the BlueCross BlueShield of Tennessee Policy for Quarterly Reimbursement updates and applicable BlueCross BlueShield of Tennessee Reimbursement Policies.

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