of Tennessee
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Upcoming Code Edits (Effective July 13, 2020)

NOTICE TO FACILITIES BILLING OUTPATIENT SERVICES

On July 13, 2020**, BlueCross BlueShield of Tennessee,** will make a change to the way we process claims for outpatient services. We'll begin applying nationally and locally supported edits designed to implement standards for correct coding and claims payment to provide greater consistency in claims processing and more accurate payment. While different edits apply to each line of business, these will be additional edits applied to outpatient for all lines of business.

You'll also find greater consistency between BlueCross outpatient edits and Centers of Medicaid and Medicare Services (CMS). This should help you and your staff more easily predict how your claims will be edited and assist you in your efforts for compliance with CMS billing and correct coding requirements. We've included a brief description of these edits to help you understand how your claims will be affected by these edits.

Summary of Edits (Applicable to one or more lines of business)

1. National Coding Policies and Guidelines

Several policies are being introduced that are based on CMS and AMA Policies and Guidelines. In most cases, these policies are similar to the policies we've already started for professional claims editing. The facility outpatient version are being introduced for hospitals and the ambulatory surgery center for professional. We're highlighting some of the more frequently encountered edits.

- **National Correct Coding Initiative (CCI)**

  The National Correct Coding Initiative (CCI) is a collection of bundling edits created and sponsored by CMS and that are separated into two major categories. The first category contains the Comprehensive and Component procedure code edits; the second has the Mutually Exclusive procedure code edits.

  Correct Coding Initiative edits are for services performed by the same facility on the same date of service only and don't apply to services performed within the global surgical period.

- **Multiple Procedure Reduction**

  Multiple Procedure Reduction rules apply when a facility performs two or more surgical procedures, identified by CMS as subject to multiple surgery guidelines, on the same date of service. The procedure with the highest value will be reimbursed at 100%, and all other services will be paid at 50% of the allowable.

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- **CMS Bundling Rules**

  A number of services/supplies covered by CMS are bundled into the payment for other related services, as applicable to each line of business.

- **AMA Code definitions and appropriateness of codes when used together**

  The AMA CPT-4 Manual and CMS HCPCS Manual have provided instructions on code usage. BlueCross has adopted edits that support correct coding based on the definition or nature of a procedure code or combination of procedure codes. These edits will bundle based on the appropriateness of the code selection.

2. Revenue Code Validation

Revenue codes are 4-digit codes used to classify types of service. They're required for accurate hospital outpatient claims processing. Revenue codes will be required for processing of all outpatient facility claims. If revenue codes are not on a claim, the charges will be denied. There are also additional rules regarding the appropriate use of revenue codes on outpatient facility claims.

- Alternatively, the CPT/HCPCS codes billed must be appropriate for use with the billed revenue code. If the codes do not match, the charges will be denied.

- Certain revenue codes are not appropriate for use with outpatient hospital claims billed by facilities. If these revenue codes are billed by facilities for outpatient claims, the claims will be denied: Specifically, Room and Board revenue codes 010X-021X are intended to be used only in the inpatient hospital setting. It's inappropriate for these codes to be billed will outpatient hospital bills (bill types 12X, 13X, 14X). Additionally, revenue codes 96X-98X are utilized to bill professional services.

3. Maximum Units of Service per Day

The Maximum Units of Service per Day Medical Payment Policy is designed to identify coding errors and prevent excessive billing of a given HCPCS code for a given date of service. The policy is applied using a member-based methodology which counts the number of units of service for a single date of service regardless of the provider (same or different provider and specialty).

The Maximum Units of Service per Day policy is derived from several sources: CMS, AMA, knowledge of anatomy, the standards of medical practice, FDA and other nationally recognized drug references, and claims data from provider billing patterns.

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4. Blood Products and Transfusion

Per the Centers for Medicaid and Medicare Services (CMS) guidelines, based on CMS Policy, when a code for blood transfusion is reported, the associated blood product code must also be reported for the same date of service.

Important Notes

- Editing will begin for any claims processed on 7/13/2020 and later.
- Only services reimbursed using a fee schedule will be subjected to these edits. Any services reimbursed by DRG, OPPS, Per diem or case rates are excluded from these edits.
- There are no changes to any processes including claims submission, customer service and support or grievances and appeals.

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