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Claims Edit and Coding Updates

Updated 18 May 25

Overview

BlueCross updated the claims payment process in August 2017 to include a more careful analysis during the pre-payment phase of claims editing, with the goal of delivering payments to providers with more accuracy, reducing the need for recovering payments that exceed claims liability. We already use this system to process claims for our BlueCare Tennessee and Medicare Advantage lines of business.

With this upgrade, our system identifies and applies pre-payment edits to claims that were not possible in the past. Some unintended or incomplete items that have passed through for payment in the past may process differently in the future. However, this update does not reduce provider reimbursement rates, your patients' benefits or the speed at which we pay your claims.

We hope the following updates help you during the claims submission process.

OCTOBER 18, 2017

Which Code is Correct, CPT or HCPCS?

Services should be coded as specifically as possible, but knowing which codes to use is determined by your patient's coverage. The Centers for Medicare and Medicaid Services develops HCPCS codes, often called "hic pics," that correspond with CPT codes that are for use with your patients covered by our government lines of business. However, for your patients who have BlueCross commercial plans, CPT codes are the way to go.

When specific services require certain codes in order to administer the program or benefit, we will provide coding guidelines.

Allergy Antigen Billing

BlueCross reimbursement for allergy antigen is based on RBRVS methodology, not the AMA description of services. Under RBRVS reimbursement, the standard CMS uses, there are three components of the code – physician's work, malpractice expense and practice expense.

Using the aliquot of 1cc as the value to calculate the practice expense, providers are compensated for the antigen prepared and supplied. The MUE is based on the most common volume of three 10cc vials or six 5cc vials.

In addition, providers are eligible to receive reimbursement each time the antigen is administered, regardless of the amount given.

OCTOBER 11, 2017

Using Right and Left Laterality Modifiers to Ensure Claims Payments

We want to help you make sure that your claims process efficiently and without any issues through our updated claims editing software. We will let you know when items that trigger a denial start appearing on a regular basis.

The following items require right (RT) and left (LT) laterality modifiers to process correctly:

DME – Wheelchair Claims

- All wheelchair accessories with a "bilateral" component require RT/LT modifiers
- All accessories billed with same code for a different level (e.g. pelvic supports, thoracic supports) require a separate line for each level
- All accessories billed with same code for front and rear components (e.g. casters) require a separate line for each section

Drugs

- J732x Hyaluronan or derivative codes (i.e. currently J7320 – J7328) require an RT/LT modifier if injections are made bilaterally.

SEPTEMBER 2017

Claims Editing Process Update Is Now Complete and Applies to Facilities

An important claims editing process update was completed the last week of August. This update moved our Commercial member claims process, which includes facility claims, to an automated system. There are also additional claims editing capabilities that allow us to process claims more efficiently. We already use this system to process claims for our BlueCare Tennessee and Medicare Advantage lines of business.

With this upgrade, our system can identify and apply pre-payment edits to claims that weren't possible in the past. Because the system performs a closer review of claims, some unintended or incomplete items that have passed through for payment in the past may process differently in the future. However, this update won't reduce contracted provider reimbursement rates, your patients' benefits or the speed at which we pay your claims.

The editing system meets industry rules and federal regulations for health care claims including modifier usage, diagnosis coding and MUEs for facilities. Additional information can be found in the NCCI Manual, BlueCross Provider Administration Manual, the Code Editing page on our website and previous editions of the BlueAlert newsletter.

Coding Tips: Key Points to Remember for Diagnosis Coding

We want to help you make sure that your claims process efficiently and without any issues, so we want to let you know when items that trigger a denial start appearing on a regular basis.

- When diagnosis codes include an age range, make sure the patient's age matches with the diagnosis code.
- The sequence of how encounter codes are listed is important. This situation happens often with chemotherapy treatments. If a patient admission/encounter is only for administering chemotherapy, immunotherapy or radiation therapy, please assign the appropriate encounter code as the first-listed or principal diagnosis. If a patient receives more than one of these therapies during the same admission, more than one of these codes may be assigned, in any sequence. The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis.

- Please follow the ICD-10 guidelines for the sequence of external codes not used for a primary diagnosis.

AUGUST 2017

Coding Tips: Submitting Evaluation and Management with Injection Services

We want to help you make sure that your claims process efficiently and without any issues, so we want to let you know when items that trigger a denial start appearing on a regular basis. If you're performing evaluation and management services and injections, infusions, immunizations or chemotherapy during the same date of service, National Correct Coding Initiative (NCCI) editing will bundle these together.

If you would like detailed information, please see the NCCI Policy Manual for Medicare Services. Chapter XI of the manual details the process of using modifiers for reporting evaluation and management services in addition to therapeutic or diagnostic infusion/injection and immunization services.

JULY 2017

Coding Tips: Post-Operation Billing for Unrelated Procedures

We want to make sure that your claims process efficiently and without any issues. So when the same issues trigger denials on a regular basis, we want you to know. Recently, more claims are being denied where incorrect modifiers are used during a global billing period.

Modifiers 24 (unrelated post-op evaluation and management) and 79 (unrelated post-op procedure) are available to help simplify the post-op billing process, but the use of these modifiers is very strict. These two modifiers are only for care that has no relation to the surgery. Including documents that support the care was unrelated to the surgery will help speed the payment of your claims.

For more information, refer to the "Medicare Claims Processing Manual", Chapter 12, Section 40.2, on the CMS website at: **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf**.

March 2017

New Claims Editing System to Be in Effect Later this Year

BlueCross plans to implement a more robust editing system for Commercial professional and facility claims in the latter part of 2017. The editing system adheres to industry rules and standards, as well as federal regulations and policies governing health care claims. You may see some slight differences in how claims are processed as a result of this change. Look for more information in upcoming issues of BlueAlert.

- New software will allow NCCI edits to be applied in real time and not a quarter behind as the current configuration handled.
- Edits will be applied on all claims processed (newly adjudicated and re-adjudicated) after implementation date regardless of date of service.
- Claims and claim lines can be denied even if a service was approved by an authorization. The service may be approved, but if the claim is not billed appropriately, the iCES software will edit the claim per applicable coding protocols.
- Guidelines for the use of "add-on" codes need to be followed. An "add-on" code billed without the primary code will not be allowed by the editor e.g. submitting 01968 and 01967 on separate claims (see Feb '17 BlueAlert)
- Make sure primary and secondary diagnosis codes are age appropriate. Refer to ICD-10 manual for correct age ranges used in diagnosis definitions.

- Be aware of Medicare status “B” (bundled) codes.
- All services for one DOS are to be filed on the same claim. Split billing does not bypass editing, but could delay claim processing.
- Many guidelines for modifier usage are published in the provider manual.
- Age appropriate Diagnosis – diagnosis code should be in range for member’s age
- External cause - review ICD-10 guidelines on sequence of eternal cause codes not used as primary diagnosis
- Encounter codes – particularly for chemotherapy administration, review sequence guidelines. If a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy assign the appropriate encounter code as the first-listed or principal diagnosis. If a patient receives more than one of these therapies during the same admission more than one of these codes may be assigned, in any sequence. The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis.

Modifier 91 Repeat Clinical Diagnostic Laboratory Test

Modifier 91 should be used to identify a repeat performance of the same clinical lab test on the same day, for the same patient to obtain subsequent results. For example, if a patient with pneumonia has arterial blood gases performed in the morning and again in the afternoon on the same day. The appropriate code for both tests is 82803 (gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3). 82803 should be reported for initial test and 82803-91 for the subsequent test.

If a test is repeated to confirm an initial result or due to equipment malfunction/failure, this not a reportable service and modifier 91 is not applicable.

Additionally, when multiple lab tests are performed to assess different strains/species of an organism, modifier 91 does not apply.

According to the CPT manual, modifier 59 should be used for "different species or strains reported by the same code" or for multiple specimens or sites. An example of this situation is 87798 *Infectious agent detection by nucleic acid (DNA or RNA) not otherwise specified; amplified probe technique each organism*. This test may be performed multiple times for different organisms. In this case, 87798 can be reported for the initial organism and 87798-59 for the additional organisms. However, if one test is performed and 3 results are obtained, only one unit may be reported for the single test. Additional information may be found in the National Correct Coding Initiative Policy Manual for Medicare Services.

Modifier 62

BlueCross follows Medicare's guidelines by assigning an indicator to each procedure code to denote whether the procedure is Medically Appropriate for co-surgery services.

Each co-surgeon from a different specialty performs a distinct portion of the complete procedure and reports the exact same surgical procedure code with the 62 modifier. Each surgeon must dictate his/her own operative report. BlueCross uses the payment policy indicators on the Medicare Physician Fee Schedule Database (MPFSDB) to determine if co-surgeon services are reasonable and necessary for a specific HCPCS/CPT® code.

If the editor identifies different procedure codes filed or the absence of the -62 modifier, the claims will be denied.