blue of california

Payment Policy

Clinical Editing Overview	
Original effect date:	Revision date:
07/08/2017	03/04/2024

IMPORTANT INFORMATION

Blue Shield of California payment policy may follow industry standard recommendations from various sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT) and/or other professional organizations and societies for individual provider scope of practice or other coding guidelines. The above referenced payment policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms or their electronic equivalent. This payment policy is intended to serve as a general overview and does not address every aspect of the claims reimbursement methodology. This information is intended to serve only as a general reference regarding Blue Shield's payment policy and is not intended to address every facet of a reimbursement situation. Blue Shield of California may use sound discretion in interpreting and applying this policy to health care services provided in a particular case. Furthermore, the policy does not address all payment attributes related to reimbursement for health care services provided to a member. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy such as coding methodology, industry-standard reimbursement logic, regulatory/legislative requirements, benefit design, medical and drug policies. Coverage is subject to the terms, conditions and limitation of an individual member's programs benefits.

Application

Blue Shield utilizes ClaimsXten™, a claims editing software product to apply clinical editing to the claims adjudication process.

ClaimsXten™, is a comprehensive, nationally recognized code auditing system which ensures consistent reimbursement by automatically evaluating provider claims in accordance with accepted industry coding standards. ClaimsXten at Blue Shield will use rules derived from a combination of coding guidelines from the Center for Medicare and Medicaid Services (CMS), American Medical Association's Current Procedural Terminology (AMA CPT) Specialty Society guidelines, input from Lyric® physician consultants, and Blue Shield's payment policy guidelines.

Claims editing software is updated periodically, without notification, to reflect the addition of newly released, revised, or deleted codes, and their associated claim edits, including but not limited to National Correct Coding Initiative (NCCI) revisions, as well as health plan payment policies.

Policy

The following is a list of ClaimsXten rules adopted by Blue Shield. This list is not a comprehensive list of all Blue Shield claim edits, but rather those implemented via ClaimsXten. Reference to a more specific Blue Shield payment policy, where applicable, is indicated.

History Editing: ClaimsXten™ is able to identify historical claims that are related to current claim submissions, which may result in adjustments to previously processed claims.

Example:
An E&M service is submitted on a claim, and then a surgery for the same service date is submitted on a different claim for the same member by the same provider. If it is determined that the reimbursement for the E&M service paid in history is included in the reimbursement for the surgery, then an adjustment of the E&M claim will be necessary, and this may result in an overpayment recovery.

This history editing capability allows Blue Shield to systemically adjudicate claims based on the guidelines of our reimbursement policies including, but not limited to, global surgery, multiple visits per day, pre/post-operative visits, new patient visits, frequency rules, incidental, mutually exclusive and re-bundle edits, and maternity services. This systemic adjudication may result in previously processed claims being adjusted if a related claim triggers history edits.

Across Provider Editing: Some edits may apply across providers.

Examples:

- When multiple claim lines are billed on the same claim or separate claims by the same provider or multiple providers, whether they are a professional, ancillary and/or outpatient service provider.
- When a single claim line or multiple claim lines are billed on the same claim or separate claims by the same physician and/or other health care professional in the same group, reporting the same federal tax identification number (TIN).
- When multiple providers submit charges eligible for across provider editing, only the first claim processed will be considered for reimbursement.

Add-On Without Base Code: Based on AMA guidelines which states, “add-on” codes are always performed in addition to the primary service/procedure, and must never be reported as a stand-alone code; claim lines containing Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) assigned as an add-on code(s) billed without the presence of one or more related primary service/base procedure(s) will be denied.

Sourcing: AMA and CMS
Application: Professional, Ancillary claims and Outpatient Facility claims

Age: This rule denies age-specific procedure codes when incorrectly assigned based on the age of the patient referenced on the claim. If an alternate, more appropriate procedure code is found that is consistent with the patient's age, it will be added to the claim, resulting in denial of the inconsistent procedure code.

Sourcing: AMA and Medicare Code Editor (MCE)
Application: Professional, Ancillary, Ambulatory Surgery Center, and Outpatient Facility claims.

Age ICD10: This rule recommends the denial of claim lines in which the diagnosis code is inconsistent with the patient's age. Age calculation uses the patient's date of birth and the line date of service.

Sourcing: CMS
Application: Professional and Outpatient Facility claims

Assistant Surgeon/Assistant at Surgery: This rule identifies procedure codes appended with an assistant surgeon modifier (80, 81, 82, AS) that do not typically require an assistant surgeon. **(Refer to the Assistant Surgeon payment policy)**

Sourcing: American College of Surgeons (ACS), CMS, Lyric® Clinical Review
Application: Professional claims

Bundled and Not Separately Payable Services: Recommends denial of services and supplies that are considered part of overall care and are not separately reimbursed. **(Refer to the Bundled and Not Separately Payable Services payment policy)**

- **Always Bundled Services and Supplies**: This rule identifies procedure and supply codes that are not eligible for reimbursement when billed with any other procedure that is not indicated as always bundled service or supply when reported by the same provider, for the same member, on the same date of service.
- **Always Denied Services and Supplies**: This rule identifies always denied services and supplies that are considered as not separately payable when billed alone or in conjunction with any other code.

Sourcing: CMS and BlueShield Policy
Application: Professional and Ancillary claims

Correct Coding Initiative: Blue Shield follows the National Correct Coding Initiatives (NCCIs) to promote correct coding methodologies to ensure appropriate reimbursement when inappropriate code combinations are reported. **(Refer to the Frequency Editing payment policy)**

- Procedure to Procedure (PTP) code pair edits: National Correct Coding Initiative (NCCI) (also known as CCI) was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI Procedure-to-Procedure (PTP) code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for covered services.

- Medically Unlikely Edits (MUEs): An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a date of service for a single member.
- Blue Shield follows NCCI modifier guidelines when applying NCCI editing, including bypass of the edit when appropriate Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass a PTP code pair edit if the clinical circumstances do not justify its use.
- The PTP code pair edits, MUE tables, and NCCI manual can be accessed through the National Correct Coding Initiative Edits webpage on the CMS website: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

Sourcing: CMS
Application: Professional, Ancillary, Ambulatory Surgery Center and Outpatient Facility claims

Evaluation & Management Services with Revenue Code 0761: This edit identifies Evaluation and Management Services reported by an outpatient facility when billed with Revenue Code 0761 (Treatment Room). Billing of Evaluation and Management Services with Revenue Code 0761 (Treatment Room) would not meet the definition of Specialty Services and will be denied when billed together. **(Refer to the Revenue Code 761 payment policy)**

Sourcing: Uniform Billing Editor, American Hospital Association, American Medical Association and National Uniform Billing Manual (NUBC)
Application: Outpatient Facility claims

Frequency/Maximum Occurrence: This rule identifies, when a procedure code is reported either per date of service, or across dates of service, and exceeds the number of times indicated by description of the procedure, or when it exceeds the number of times it is clinically appropriate or possible to perform. When procedures or quantity of units are identified as billed inappropriately, the claim will deny the multiple line items; or deny the units exceeding the allowed frequency and replace with a new corrected line item showing the appropriate number of units or a more comprehensive code. **(Refer to the Frequency Editing payment policy)**

Sourcing: AMA and Lyric® Clinical Review
Application: Professional, Ancillary claims, Ambulatory Surgery Center, and Outpatient facility claims

Code and Modifier Validation: Recommends denial of claim line(s) containing invalid CPT/HCPC code, Diagnoses, or Modifiers.

- CPT/HCPC code validation: This rule is based on the American Medical Association's Current Procedural Terminology (AMA/CPT) and Healthcare Common Procedure Coding System (HCPCS).
- Modifier validation: This rule is based on (AMA), HCPCS modifiers published by the Centers for Medicare and Medicaid Services (CMS).
- Diagnoses validation: This rule is based on World Health Organization (WHO ICD-10 CM) and CMS when determining additional digit requirements (4th and 5th digit).
- Modifier to Procedure validation: This rule is based on AMA/CPT, CMS, and Lyric® sourcing. (Refer to the Modifier Reimbursement payment policy)

Sourcing: AMA, CMS, the ICD-10-CM Official Guidelines for Coding and Reporting posted on the NCHS website and Lyric® Clinical Review.
Application: Professional, Ancillary and Outpatient Facility claims

Co-Surgeon: Co-Surgery modifier –62 may be appropriately appended to a variety of surgical procedures that may require co-surgeons for the successful performance of the procedure. This edit recommends review for medical necessity or denial of claim lines containing procedure codes, submitted with co-surgery modifier –62 in any of the four modifier positions, where there is a payment restriction for co-surgery according to the CMS Medicare Physician Fee Schedule RVU file status indicators.

- Procedure codes in the CMS Physician Fee Schedule (MPFS) Relative Value File with status code indicator of "0" are not allowed.
- Procedure codes in the CMS Physician Fee Schedule (MPFS) Relative Value File with status code indicator of "1" for "Co-Surgeons" will be sent for medical review and may require supporting documentation to establish the medical necessity of two surgeons for the performance of the procedure.
- Procedure codes in the CMS Physician Fee Schedule (MPFS) Relative Value File with status code indicator of "2" for "Co-Surgeons" are allowed when billed in accordance with CMS guidelines: If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier –62 (Two Surgeons).

Sourcing: CMS and BlueShield Policy
Application: Professional claims

Global Component: This rule identifies claim lines submitted with procedure codes eligible for professional component (modifier –26) and technical component (modifier –TC) reimbursement to prevent overpayments when duplicate submissions occur for the total global procedure or its components across different providers. Only one physician or other health care professional will be reimbursed when duplicate submission occurs for the total global procedure or its components when submitted for the same patient on the same date of service on separate claim lines or on different claims. **(Refer to the Global Component payment policy)**

This edit applies to claims with date of service 07/08/2017 and after.

Sourcing: CMS
Application: Professional and Ancillary claims

Imaging Guidance for Varicose Vein Surgery: This rule will deny as incidental to the primary procedure any imaging guidance and monitoring (Doppler, Duplex Ultrasound or Fluoroscopy) when performed on the same date of service as the Varicose Vein Surgery by the same provider. **(Refer to the Imaging Guidance for Varicose Vein payment policy)**

Sourcing: BlueShield payment policy
Application: Professional, Ancillary and Outpatient facility claims

Image Guided Radiation Therapy: This rule will deny Image guided radiation therapy codes when billed on the same date of services for the same member as Intense-Modulated Radiation Therapy (IMRT), Stereotactic body radiation therapy (SBRT), or Stereotactic radiosurgery (SRS) treatment services. (Refer to the Image Guided Radiation Therapy payment policy)

This edit applies to claims with date of service 05/14/2023 and after.

Sourcing: Blue Shield payment policy
Application: Professional and Outpatient facility claims

Lab Panel and Individual Component Billing: This rule denies two or more automated laboratory test components reported when the sum of the value-based laboratory test components exceeds the value of an all-inclusive automated test panel. The closest related automated test panel code that is comprised of components in common with those submitted on the claim is added to the claim, resulting in the component procedures being disallowed. Automated test panels are individual laboratory tests that clinical laboratories typically perform at the same time on the same automated equipment. CPT describes these laboratory tests as Organ or Disease-oriented Panels and identifies the component tests that make up a particular panel. **(Refer to the Laboratory Panel payment policy)**

This edit applies to claims with date of service 07/08/2017 and after.

Sourcing: AMA, CMS, Lyric® Clinical Review and BlueShield policy
Application: Professional and Ancillary claims

Missing Professional Component (Modifier –26): This rule identifies claim lines submitted with procedure codes eligible for professional component (modifier 26) when billed by a professional provider in a facility place of service (21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56, and 61). When CMS designates modifier –26 is applicable to a procedure, and it is reported by a professional provider for the technical component (modifier TC) in a facility setting, the claim line will be denied or, if billed as a global service (no modifier) in a facility setting, the claim line will be replaced with a new line with the same procedure and modifier 26 will be added. **(Refer to the Professional Component payment policy)**

CMS' National Physician Fee Schedule Relative Value File (NPFSRVF) designates that modifier –26 is applicable to a procedure code (PC/TC indicator of 1 or 6), and the procedure (e.g., radiology, laboratory, or diagnostic) has been reported by a professional provider with a facility-based place of service, the procedure code must be reported with modifier –26.

Sourcing: CMS
Application: Professional and Ancillary claims

Multiple Procedure Reductions: This rule identifies claim lines that are eligible for a multiple procedure reduction and assigns appropriate pay percentage to the eligible line(s). Multiple procedure reduction is 100% for the primary procedure and 50% for each subsequent procedure. **(Refer to the Multiple Procedure & Endoscopy Reduction payment policy)**

Sourcing: AMA, CMS
Application: Professional and Ancillary claims

Multiple Endoscopy Reductions: This rule identifies multiple endoscopy procedures reported within the same family and applies the multiple endoscopy reduction, per Center for Medicare & Medicaid Services (CMS) guidelines. In addition, if more than one endoscopy family is reported and/or surgery procedures are reported, the rule will apply the multiple surgery cutback to the appropriate endoscopy family or families and surgery procedures. Multiple procedure reduction is 100% for primary procedure and lower percentage based on CMS guidelines for each subsequent procedure. **(Refer to the Multiple Procedure & Endoscopy Reduction payment policy)**

This edit applies to claims with date of service 07/08/2017 and after.

Sourcing: AMA, CMS
Application: Professional claims

Multiple Diagnostic Cardiology Reductions: This rule identifies claim lines that are eligible for a multiple diagnostic cardiology service reduction and assigns appropriate pay percentage to the technical component. Multiple procedure reduction is 100% for the primary procedure and 75% for each subsequent procedure. (Refer to the Multiple Diagnostic Cardiology Reductions payment policy)

This edit applies to claims with date of service 07/08/2017 and after.

Sourcing: CMS
Application: Professional and Ancillary claims

Multiple Diagnostic Ophthalmology Reductions: This rule identifies claim lines that are eligible for a multiple ophthalmology service reduction and assigns appropriate pay percentage to the technical component. Multiple procedure reduction is 100% for the primary procedure and 80% for each subsequent procedure. **(Refer to the Multiple Diagnostic Ophthalmology Reductions payment policy)**

This edit applies to claims with date of service 07/08/2017 and after.

Sourcing: CMS
Application: Professional and Ancillary claims

Multiple Physical Medicine & Chiropractic Manipulation Treatment Reductions: This rule identifies claim lines that are eligible for multiple procedure reduction and assigns appropriate pay percentage. Physical Medicine and Rehabilitation, Therapeutic Procedures, Active Wound Care Management, Orthotic and Prosthetic Management, and Chiropractic manipulation services will be processed using a tiered reimbursement methodology based on the highest to lowest RVU value and will be reimbursed at a percentage of the current fee schedule. The tiered reimbursement methodology will be applied when billing multiple services, individual services, or multiple units of the same service. **(Refer to the Physical Medicine payment policy)**

Sourcing: BlueShield payment policy
Application: Professional claims

Multiple Radiology Reductions: This rule identifies claim lines that are eligible for a multiple diagnostic imagine service reduction and assigns appropriate pay percentage to the technical component. Multiple procedure reduction is 100% for the primary procedure and 50% for each subsequent procedure. **(Refer to the Multiple Diagnostic Imaging Reductions payment policy)**

Sourcing: CMS
Application: Professional claims

New Patient Evaluation and Management: According to the AMA, "A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years." Claim lines containing new patient procedure codes that are submitted for established patients will be denied when AMA billing guidelines are not met.

This edit applies to claims with date of service 07/08/2017 and after.

Sourcing: AMA
Application: Professional claims

Obstetric Anesthesia: This rule denies obstetric anesthesia services billed by the same provider, for the same patient, during the same session when billed in excess of 23 units. Payment for obstetric anesthesia, when allowed, is reimbursable as the Base unit, plus Time units, plus Modifier units, subject to a maximum cap of 23 units. The maximum of 23 units would apply to labor and a subsequent caesarean section, if necessary, when billed for the same patient. **(Refer to the Anesthesia Services payment policy)**

Sourcing: BlueShield payment policy
Application: Professional claims

Moderate Sedation Services: Consistent with CMS and CPT guidelines and national standards, this rule denies moderate sedation (CPT 99155-99157) services when billed by a physician other than the physician performing the diagnostic or therapeutic service in the non-facility setting (e.g., physician office, free-standing imaging center). **(Refer to the Anesthesia Services payment policy)**

Sourcing: AMA
Application: Professional claims

CRNA's billing for Anesthesia Services: This rule will deny CRNA claims when billing for anesthesia services without modifier QS, QX or QZ. Blue Shield of California requires CRNA's to use the applicable modifiers when they are providing Anesthesia services. **(Refer to the Anesthesia Services payment policy)**

- Modifier QS: Monitored anesthesiology care services
- Modifier QX: Qualified non-physician anesthetist with medical direction by a physician
- Modifier QZ: CRNA service- without medical direction by a physician

Sourcing: BlueShield payment policy
Application: Professional claims

Hospital Admission, Discharge and Observation Services: This rule identifies claim lines submitted for multiple initial inpatient admission, hospital discharge services and initial observation services across different providers. Only one physician or other health care professional will be reimbursed for the initial inpatient admission, hospital discharge and initial observation services when submitted for the same patient on the same date of service, per hospital admission. **(Refer to the Hospital Admission, Discharge and Observation Services payment policy)**

This edit applies to claims with date of service 07/08/2017 and after.

Sourcing: AMA and CMS
Application: Professional claims

Preventive and Problem Oriented E/M: This rule identifies claim lines that are eligible for Pay Percent adjustments when Preventive and problem-oriented E/M services are reported by the same physician for the same patient on the same day. A 50% reduction is applied to the problem-oriented service because a component of the service was already performed during the preventive visit. **(Refer to the Preventive and Problem Oriented E/M Reduction payment policy)**

This edit applies to claims with date of service 07/08/2017 and after.

Sourcing: BlueShield payment policy
Application: Professional claims

Pre-Op/Post-Op: This rule recommends the denial of an E/M service, when billed by the surgeon or by members of the same group with the same specialty, one day prior to or during the 10 or 90-day global surgical period. **(Refer to the Global Surgical Period payment policy)**

Sourcing: CMS, American Academy of Orthopedic Surgeons (AAOS) and BlueShield payment policy
Application: Professional claims

Procedure Code Re-bundling: This rule recommends the denial of claim lines containing procedure codes typically not recommended for reimbursement when submitted with certain other procedure codes on the same date of service. It identifies code pairs that are created based on coding standards relative to procedure codes that would not reasonably be performed on the same date of service or procedure codes that are a component of another procedure code.

Sourcing: AMA, Lyric® Clinical Review
Application: Professional and Ancillary claims

Procedure Code Unbundling: This rule recommends the denial of claim lines containing two or more procedure codes used to report a service when a single, more comprehensive procedure code exists that more accurately represents the service performed. This is typically identified by the CPT code description of each code. Occasionally, the code that represents the comprehensive procedure is added to the claim resulting in the component procedures being denied.

Sourcing: AMA, Lyric® Clinical Review
Application: Professional and Ancillary claims

Procedure to Place of Service: This rule recommends the denial of claim lines containing procedure codes reported in a place of service (POS) considered inappropriate, based on the code's description or available coding guidelines as defined by American Medical Association's (AMA) Current Procedure Terminology (CPT). For example, inpatient admission procedure code(s) are performed in an inpatient facility setting; therefore, a POS of 'office' would not be appropriate. **(Refer to the Procedure to Place of Service payment policy)**

This edit applies to claims with date of service 07/08/2017 and after.

Sourcing: AMA
Application: Professional claims

Same Day Medical Visit: This rule recommends the denial of an E/M service when billed on the same day as a surgical procedure by the surgeon or by members of the same group with the same specialty. **(Refer to the Global Surgical Period payment policy)**

Sourcing: CMS, BlueShield payment policy
Application: Professional claims

Scope of Practice: This rule will deny services considered out of scope for the provider. Blue Shield of California allows reimbursement for services that are within the provider's scope of practice under state law in accordance with CMS guidelines unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise. (Refer to the Scope of Practice payment policy)

Sourcing: BlueShield payment policy
Application: Professional, Ancillary and Outpatient facility claims

Unlisted/By Report Codes: Blue Shield manually reviews claims submitted with unlisted/by report CPT and HCPCS codes since these types of codes generally do not have an established fee. Appropriate medical records such as operative reports, visit documentation, and manufacture invoices are required for services/claims billed with unlisted or by report codes in order to define an appropriate allowance.

Sourcing: AMA, Lyric® Clinical Review
Application: Professional, Ancillary and Outpatient facility claims

Rationale

Blue Shield utilizes claims editing software that uses correct coding from industry standard sources, such as Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPC) and health plan developed policies as applicable during the claims adjudication process. Additional sources may be used as defined in the claim edit descriptions noted above.

Reimbursement Guideline

Blue Shield of California will reference national or regional industry standards, such as Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and MUE (Medically Unlikely Edits) rules, and American Medical Association's (AMA) CPT guidelines, as coding standards and as guidance for payment policy. In claims payment scenarios where CMS and/or CPT reference is lacking or insufficient, the Payment Policy Committee (PPC) may develop customized payment policies that are based on other accepted or analogous industry payment standards and or expert input.

Resources
• **American Medical Association** https://www.ama-assn.org/ama • **Centers for Medicare & Medicaid Services** https://www.cms.gov/ • **CMS Medicare Physician Fee Schedule (MPFS) Relative Value File** https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Payment Policy.

Effective Date	Action	Reason
07/08/2017	New Policy Adoption	Payment Policy committee
01/12/2018	Maintenance	Payment Policy committee
08/03/2018	Maintenance	Payment Policy committee
04/01/2020	• Same Day Repeat Lab (standalone edit) deleted. In alignment with CMS, this is no longer a standalone edit. However, frequency editing for repeat lab procedures will continue to apply via the CMS MUE edit. • Added Scope of Practice Policy details.	Annual Maintenance

Effective Date	Action	Reason
04/01/2022	• Added ICD10 AGE MADV • Updated Add-on without base code to include outpatient • Minor verbiage and formatting updates	Quarterly Maintenance
01/01/2024	• Added Image Guided Radiation Therapy • Formatting updates	Annual Maintenance
03/04/2024	• Updated ClaimsXten vendor name from Change Healthcare to Lyric	Maintenance

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under an enrollee's contract.

These Policies are subject to change as new information becomes available.