Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

General Coding

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Description

Medical coding is the process of converting diagnosis, procedures and supply information provided by healthcare individuals into ICD-10, CPT and HCPCS codes for billing purposes.

Billing is the process of electronically filing claims electronically to Blue KC using encrypted technology to secure patient information.

Policy

Blue KC reimburses:

- Current Procedural Terminology (CPT) Level I codes
  - Five-digit numeric codes maintained by the American Medical Association (AMA). Used to describe medical, surgical, and diagnostic services, including radiology, anesthesiology, and evaluation and management services of physicians, hospitals, and other healthcare providers.
- Healthcare Common Procedure Coding System (HCPCS) Level II codes
  - Alpha-numeric codes (one letter followed by four numbers) for medical services not included in Level I. For example, durable medical equipment, ambulance services, drugs, and supplies.
- HCPCS National "S" codes
  - Temporary codes for private payer use.
- Current Dental Terminology (CDT) codes
  - Dental codes maintained by the American Dental Association (ADA).
- International Classification of Diseases, 10th revision (ICD-10-CM)
  - ICD-10 codes are used to indicate diagnosis or condition and are required on all claims.

- Revenue codes
    - Four-digit numeric codes used by institutional providers. HCPCS or CPT codes may be required in addition to specific revenue codes, to describe the services rendered.
- Modifiers
    - CPT and HCPCS - Two-character alpha and numeric codes used to add additional information to coding.
- Add-on codes
    - When billed with a qualifying primary CPT or HCPCS code and may not be billed as the sole service provided.
- Services reported with a TC (Technical component) or -26 (professional component) modifier for procedures that allow these modifiers, as defined by the CMS National Physician Fee Schedule Relative Value File.

Blue KC does not reimburse:

The procedures or categories of codes outlined below. This list is not all inclusive.

- Category II CPT codes (XXXXF). This code set is a set of supplemental tracking codes that can be used for performance measurement and are intended to facilitate data collection. Using these codes is optional for correct coding, and may not be used as a substitute for Category I codes. These codes are intended to facilitate data collection about quality of care. If billed, they will deny with provider liability.
- Bundled services/supplies (Status "B"). Codes identified with a CMS indicator of "B" (bundled code) in the National Physician Fee Schedule Relative Value File will not be separately reimbursed by Blue KC. Payments for these procedures are always bundled into payment for other services and separate payment is never made. If billed, they will deny with provider liability. (Please refer to CMS guidelines for additional information.)
- PC/TC Indicator 5 codes. Blue KC will deny "Incident To" codes identified with a CMS PC/TC indicator 5 in the National Physician Fee Schedule Relative Value File when reported in a facility and billed by a physician. If billed 2 of 6 incorrectly, PC/TC indicators will deny with provider liability. (Please refer to CMS guidelines for additional information.)
- "T" codes
    - HCPCS codes exclusively for the use of state Medicaid agencies. Blue KC does not reimburse "T" codes except for a limited number of contracts and services. If billed incorrectly, it will deny with provider liability.

- "M" codes
    - HCPCS codes used for measurement and reporting.
- Multianalyte Assays with algorithmic analysis not assigned a Category I CPT code.
- A HCPCS code when an equivalent or similar CPT code exists describing the same service or procedure, unless directed otherwise in a specific policy.
- C-codes when an equivalent CPT code exists. If an equivalent does not exist, a claim submitted with a C-code may be reimbursable.
- NOC (not otherwise classified) or unlisted codes without supporting documentation.
- Hospital mandated on-call service.

General reimbursement information:

Claims editing

Blue KC uses claims editing software for:

- Automated claims coding verification.
- To ensure that Blue KC is processing claims in compliance with general industry standards.
    - The policies included in the claims editing software are incorporated as policies of Blue KC.

The claims editing software:

- Uses a comprehensive set of rules.
- Provides consistent and objective claims review by reviewing both the CPT and HCPCS codes submitted and by detecting inaccuracies in coding including unbundling, up-coding, fragmentation, duplicate coding, invalid codes, and mutually exclusive code pairs.
- Updated quarterly to incorporate the most recent medical practices, coding practices, annual changes to the AMA's CPT manual, and other industry standards.

Assistants

- Individuals in training (e.g., students, trainees, interns, residents, and fellows) are not considered an assistant and services are not reimbursable, unless otherwise communicated in writing by Blue KC.
- Unless otherwise prohibited by Blue KC administrative policies, procedures, coding requirements, guidelines, rules or regulations, we reimburse no more than three assistants (to the extent consistent with the applicable law or regulation) who satisfy the following criteria:
    - The assistant is salaried, employed, or reimbursed for services by that individual provider, professional corporation, or group practice.

- The assistant is licensed to perform such services, if applicable, and comply with all other registration, certification, accreditations and/or requirements applicable to the assistant's profession.
- The assistant performs the services under the direct, personal, and continuous supervision of a Blue KC participating individual provider ("assistant's supervising provider") who is licensed to perform the services rendered and is permitted under the assistant's practice guidelines and/or regulations to supervise the assistant, except to the extent permitted in writing by Blue KC.
- "Direct, personal, and continuous supervision" means that the assistant's supervising provider actively participates in the continuing management of the patient's treatment, and is on the same premises and immediately available to give personal assistance and direction. Availability by telephone or electronic media does not constitute direct, personal, and continuous supervision, although the assistant's supervising provider need not be in the room where the assistant renders services.
- The assistant's supervising provider must provide documentation or attestation of the collaboration in the medical record by signing and dating the member's chart in accordance with our written guidelines.
- The assistant performs services that are within the scope of the supervising provider's license and are customarily included in that supervising provider's bill, regardless of the patient's method of payment.
- Reimbursement for covered services by an assistant may differ from the provider fee schedule.

Payment for clinician services in a hospital teaching setting only

Blue KC does not reimburse services performed by trainees alone. Blue KC will reimburse credentialed and contracted teaching clinicians for their oversight of services performed by trainees. The teaching clinician must cosign any notes documented in the medical records by trainees and the teaching clinician must also document at a minimum:

- The specific services he or she personally performed.
- The specific critical or key portions of services performed by trainees in which he or she was present.
- His or her participation in the management of the patient.
- The combined entries into the medical record by the teaching clinician and trainee constitute the documentation for the service and together must support the medical necessity of the service. Documentation by

the trainee or the presence and participation of the teaching clinician is not sufficient to establish the presence and participation of the teaching clinician. The teaching provider must complete their documentation in the medical record before submitting claims to ensure notations by trainees are accurate and complete to support correct coding of services.

Assist at Surgery

Blue KC reimburses the following for assist at surgery services:

Physicians, Nurse Practitioners -Specialty Care (NP-SC), Physician Assistants– Specialty Care (PA-SC), and Certified Nurse Midwives (CNM)

Locum Tenens

A locum tenens physician is a physician who works in place of the regular physician when that physician is absent, or when a hospital or practice is short-staffed. A locum tenens physician is credentialed following the same criteria as any network physician. Blue KC does not cover services provided by a locum tenens physician unless the physician is credentialed and contracted with Blue KC.

Specific billing guidelines

- Please note, the absence or presence of a procedure code or service does not imply or guarantee coverage or reimbursement.
- Blue KC will accept only standard diagnosis and procedure codes that comply with HIPAA (Health Insurance Portability and Accountability Act) transaction code set standards.
- The assistant eligible to participate with us must have a national provider identifier (NPI) and bill under that NPI (in 24J lower on the CMS-1500 form). There are exceptions to this rule for certain provider types.

CODES	DESCRIPTORS	NOTES
0001F-9007F	Category II CPT codes	Not reimbursed
0002M, 0004M, 0006M, 0007M,	Multianalyte assays with algorithmic analyses (MAAA) codes	Not reimbursed
00100-99607	Category I CPT code	

0019T-0542T	Category III CPT codes	Valid for applied behavior analysis (ABA), effective 10/1/16
99026	Hospital mandated on call service; in-hospital, each hour	Not reimbursed
90927	Hospital mandated on call service; out-of-hospital, each hour	Not reimbursed
M1000-M1071	Measurement codes	Not reimbursed, for reporting only
PC/TC Indicator 5 codes (CMS National Physician Fee Schedule RVU file)	Codes that describe services incident to a physician's service when provided by auxiliary personnel employed by the Physician in an inpatient or outpatient setting	PC/TC indicator 5 code not reimbursed to physicians in a facility
Status B codes (CMS National Physician Fee Schedule RVU file)	Covered service codes billed by a physician or other qualified health professional for which payment is always bundled into other non-specified services	Status "B" bundled code not reimbursed either when billed alone or with another service
T1000T5999	HCPCS temporary national codes established by Medicaid	See statement above for reimbursement information
A0021V5364	HCPCS level II codes	

When submitting claims for reimbursement, report all services with:

- Up-to-date industry-standard procedure and diagnosis codes.

- Modifiers that affect payment in the first modifier field, followed by informational modifiers. See Modifier Payment Policy for more information.

Documentation Submission

Documentation must identify and describe the procedures performed. If a denial is appealed, supporting documentation must be submitted with the appeal.

Coverage

The following applies to all claim submissions;
All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to the current Blue KC Medical Policy criteria, policies found under Provider Payment Policy, Provider Office Guide, and all other provisions of the Provider Service Agreement. In the event that any new codes are developed during the course of the Provider's Agreement, such new codes will be paid according to the standard or applicable Blue KC fee schedule until such time as a new agreement is reached and supersedes the current Provider's Agreement. Eligible services will be subject to the subscriber benefits, Blue KC fee schedule amount, and any coding edits.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated, if appropriate, using the appropriate facility or non-facility components, based on the site of service identified, as submitted by provider.

Policy History

DATE	DESCRIPTION
	Approval Date
7/1/19	Effective Date