Kansas City

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Re: IMPLEMENTATION OF FACILITY CLAIMS EDITING

Dear Provider Partner:

WHY YOU'RE RECEIVING THIS LETTER

Effective November 5, 2021, Blue Cross and Blue Shield of Kansas City (Blue KC) will enhance the method used to process claims for inpatient and outpatient services. To provide greater consistency in claims processing and more accurate payment determination, we will enhance our application of nationally and locally supported payment policies, which are designed to support correct coding standards. These enhancements will occur in addition to the policies already in effect and will be implemented for all lines of business.

Blue KC has historically reviewed facility claims post-payment for incorrect payments related to improper coding. Applying the below edits will reduce the number of retrospective recoupments.

WHAT YOU NEED TO KNOW

Outpatient CCI Bundling

This edit is applied for claims containing code pairs found to be unbundled or are mutually exclusive, according to Centers for Medicare and Medicaid Services (CMS) Integrated Outpatient Code Editor (I/OCE), and will deny for the following reasons:

- If the billed procedure is a component of a comprehensive procedure also billed, the component code is not allowed by the Correct Coding Initiative (CCI), and the claim line found to be unbundled from another code will deny.
- If multiple component procedures are billed when the more correct code would have been a panel code, the component codes will deny.
- Procedure is a mutually exclusive procedure that is not allowed by CCI.

Example: A claim is submitted with procedure code 11104 on 8/2/21. A second claim was submitted with procedure code 10021 for the same member, same provider and same date of service. The current claim line with procedure 11104 is denied.

Unbundled Pairs Outpatient

This edit identifies claim lines where the submitted procedure is not recommended for reimbursement when submitted with one of the following:

- A more comprehensive procedure
- A procedure that results in overlap of services
- Procedures that are medically impossible or improbable to be performed together on the same date of service

In certain cases, modifiers are considered and may potentially override the recommendation for denial.

Example: A facility submits a claim for procedure code 24800 and procedure code 29105 with no modifiers for the same member and the same date of service. Procedure code 29105 is denied as an incidental procedure to the more complex primary procedure code 24800.

MUE Outpatient Hospital

This rule identifies claim lines where the MUE has been exceeded for a CPT/HCPCS code with MUE adjudication indicator (MAI) = 1, 2 or 3, reported by the same provider, for the same member and on the same date of service.

- MAI = 1 claim line edit
- MAI = 2 date of service edits (based on policy)
- MAI = 3 date of service edits (based on clinical benchmarks)

***National Correct Coding Initiative Policy Manual, Chapter I, General Correct Coding Policies, under Section V* for Medically Unlikely Edits (MUEs) state:**

- "An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances allowable by the same provider for the same beneficiary on the same date of service. The ideal MUE value for a HCPCS/CPT code is the unit of service that allows the vast majority of appropriately coded claims to pass the MUE."

- The MUE values are based upon anatomic considerations, HCPCS/CPT code descriptors, HCPCS/CPT instructions, CMS policies, nature of analyte, nature of service/procedure, nature of equipment and/or clinical judgment prescribing information and claims data. In addition to the MUE value assigned to each procedure code in the MUE table, a MAI (MUE adjudication indicator) value of 1, 2 or 3 is also assigned.

QUESTIONS?

We value and appreciate you as our partner in providing quality care. If you have questions about any of this information, please call the Blue KC Provider Hotline at 816-395-3929.