SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.1 GENERAL BILLING

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

GENERAL BILLING GUIDELINES

PROCEDURE AND DIAGNOSIS CODES AND GUIDELINES

Blue Cross uses Physicians' Current Procedural Terminology (CPT®), ICD-10-CM and HCPCS codes for processing claims. **Participating providers should follow the coding guidelines published in the current edition of the CPT code book when submitting claims to Blue Cross for processing. Blue Cross follows these coding guidelines unless otherwise identified in our policies.** Because medical nomenclature and procedural coding is a rapidly changing field, certain codes may be added, modified or deleted each year. Please ensure that your office is using the current edition of the code book, reflective of the date of service of the claim. The applicable code books include, but are not limited to, ICD-10-CM Volumes 1 and 2; CPT and HCPCS. Inpatient procedures are found in the ICD-10-PCS coding book.

New CPT codes will be accepted by Blue Cross as they become effective.

Helpful Hints for Diagnosis Coding

- Always report the primary diagnosis code on the claim form. Principal Diagnosis – "Reason for service or procedure."
- Report up to 12 (four per line) diagnosis codes on the CMS-1500 and up to 26 diagnosis codes on the UB-04 when services for multiple diagnoses are filed on the same claim form.
- Report all digits of the appropriate ICD-10-CM code(s).
- Report the date of accident if the ICD-10-CM code is for an accident diagnosis.
- HIPAA regulations require valid ICD-10-CM diagnosis codes.

DIAGNOSIS CODE SPECIFICITY

Blue Cross requires diagnosis code specificity when filing claims. It is important to file "ALL" applicable diagnosis codes to the highest degree of specificity. Use the following specificity rules for filing claims:

- Always report the most specific diagnosis codes. Example: Only use 3-digit ICD-10 codes when 4-digit codes are not available and 4-digit codes when 5-digit codes are not available in a particular category. Always report the most specific codes.
- Always include ALL related diagnoses, including chronic conditions you are treating the member for.
- Always include an additional code when required to provide a more complete picture. For example, in etiology/manifestation coding, the underlying condition is coded first followed by the manifestation.
- Medical records must support ALL diagnosis codes on claims.

- Filing claims with NOS (not otherwise specified) and NEC (not elsewhere classified) diagnosis codes is not preferred. Filing claims with NOS and NEC codes delays claim processing and may result in Blue Cross requesting medical records. It may also result in delayed payment and possible payment reductions.
- Reporting a header code on a claim is considered to be an incomplete code and the claim will be returned to the provider as "incomplete."

Example of specific ICD-10 coding:

not billable	M86.44 Chronic osteomyelitis with draining sinus, hand	header
preferred	M86.441 Chronic osteomyelitis with draining sinus, right hand	specified
preferred	M86.442 Chronic osteomyelitis with draining sinus, left hand	specified
not preferred	M86.449 Chronic osteomyelitis with draining sinus, unspecified hand	unspecified

Commercial Risk Adjustment

Blue Cross is using the Commercial Risk Adjustment (CRA) model that the Affordable Care Act (ACA) has adopted to predict healthcare costs based on enrollees in risk-adjustment-covered plans. The model incorporates organized diagnosis codes also known as HCCs (hierarchical condition categories) that correlate or link to corresponding diagnosis categories. It is critical that Blue Cross receive complete and accurately coded claims to properly indicate our members' health status.

It is best practice to submit all applicable diagnosis codes and CPT II codes on the original claim. However, providers can submit additional diagnosis codes with 99080 or CPT II codes on a supplemental electronic claim form. The codes should be filed as a $0 charge.

REPORTING NATIONAL DRUG CODE (NDC) ON CLAIMS

We require all clinician administered drugs billed on professional and outpatient hospital claims to be processed through the member's medical benefits, and to include the NDCs for the drugs. Providers are required to report NDCs on claims with any associated HCPCS or CPT codes, including immunizations. (HCPCS codes beginning with the letter "A" are excluded from this requirement.) Failure to report an NDC on these claims will result in automatic rejections.

Providers should use the following billing guidelines to report NDCs on professional and outpatient hospital claims:

- NDC code editing will apply to any clinician administered drug billed on the claim, including immunizations. The claim must include any associated HCPCS or CPT code (except HCPCS codes beginning with the letter "A").
- Each clinician administered drug must be billed on a separate line item.

- Claims that do not meet the requirements will be rejected and returned on your "Not Accepted" report. Units indicated would be "1" or in accordance with the dosage amount specified in the descriptor of the HCPCS/CPT code appended for the individual drug.
- Providers may bill multiple lines with the same CPT or HCPCS code to report different NDCs.
- The following NDC edits will apply to electronic and paper claims that require an NDC but no valid NDC was included on the claim.
  - NDCREQD – NDC CODE REQUIRED
  - INVNDC – INVALID NDC

You must enter the NDC on your claim in the 11-digit billing format (no spaces, hyphens or other characters). If the NDC on the package label is less than 11 digits, you must add a leading zero to the appropriate segment to create a 5-4-2 format. If the NDC is not submitted in the correct format, the claim will be denied.

Revenue Code 250

For outpatient claims, when revenue code 250 is billed without an NDC and HCPCS/CPT code (when applicable) that line will not be reimbursed. This only applies to claims where Blue Cross is the primary payor.

For Hardcopy Claims

- On the CMS-1500 claim form, report the NDC in the shaded area of Block 24A. We follow CMS guidelines when reporting the NDC. The NDC should be preceded with the qualifier N4 and followed immediately by a valid CMS 11-digit NDC code fixed length 5-4-2 (no hyphens), e.g., N49999999999. The drug quantity and measurement/qualifier should be included.
- On the UB-04 claim form, report the NDC and the quantity in Block 43 (description field). We follow the CMS guidelines when reporting the NDC. The NDC should be preceded with the qualifier N4 and followed immediately by a valid CMS 11-digit NDC code fixed length 5-4-2 (no hyphens), e.g., N49999999999. The drug quantity and measurement/qualifier should be included.

For Compound Drugs

Compound drugs must be submitted hardcopy. The following information must be included when submitting a compound drug in order for the drug to be priced appropriately:

- NDC number for each drug
- Drug name(s)
- Quantity of each drug
- Total quantity of compound
- Units of measure
- Invoice - see Unlisted Codes section on Page 5.1-7

For Electronic Claims

Report the 11-digit NDC in loop 2410, Segment LIN03 of the 837. The NDC will be validated during processing. The corresponding quantity and unit(s) of measure should be reported in loop 2410 CTP04 and CTP05-1. Available measures of units include the international unit, gram, milligram, milliliter and unit.

For iLinkBlue Claims (Professional Only)

Select 24K to expand the claim line to report the NDC, Quantity and Measurement.

- NDC Code Field: Enter the 11-digit NDC code. No alpha characters, spaces or hyphens can be present.
- Quantity: Numeric value of quantity
- Measurement: Select the appropriate measurement from the drop-down menu
  - F2 – International Unit
  - GR – Gram
  - ME – Milligram
  - ML – Milliliter
  - UN – Unit

REFER MEMBERS TO NETWORK PROVIDERS

As a participating provider in our networks, you agree to assist us in our efforts to keep our members' costs down. One way to do that is to refer our members—your patients—to providers in their network.

This is important because members may pay significant costs when using a non-participating provider. The amounts that some non-participating providers charge for their services are higher than the negotiated allowable charges participating providers have agreed to accept. When seeing a non-participating provider, the member may be responsible for the difference between the allowed amount and the billed charge.

In the interest of affordable, quality care for your patients, it is important that you refer your Blue Cross patients to providers in their network. To confirm if a provider is participating, please consult our online directories.

Note: Providers who repeatedly refer members to non-participating providers could be subject to an overall reimbursement rate reduction by Blue Cross by a certain percentage as determined by Blue Cross in its sole discretion.

INVALID PROCEDURE CODES

Blue Cross may determine that certain CPT/HCPCS codes are not valid for submission to Blue Cross and may choose to require a different code to be billed to represent those services (e.g., 97140 should be used for dry needling instead of 20560 or 20561).

Unless Blue Cross gives specific written billing instructions to use the following codes, they are considered invalid for Blue Cross purposes.

- HCPCS codes when an equivalent or similar CPT code exists describing the same service or procedure (e.g., CPT drug screen codes 80320-80377 should be billed instead of HCPCS codes G0480-G0483)
- Medicaid codes H0001-H2037 and T1000-T9999
- C1000-C9999 for providers other than hospitals

ALLOWABLE CHARGES

Blue Cross reimburses participating providers based on allowable charges. The allowable charge is the lesser of the submitted charge or the amount established by Blue Cross as the maximum amount allowed for provider services covered under the terms of the Member Contract/Certificate. You should always bill your usual charge to Blue Cross regardless of the allowable charge.

Codes without established fees (e.g., IC or DC) may be reviewed and reimbursed at the plan-determined professional allowance/allowable charge or a standard discount charge as determined by the Plan.

Blue Cross regularly audits our allowable charge schedule to ensure that the allowable charge amounts are accurate. From time to time we must adjust an allowable charge because it may have been incorrectly loaded into our system or the CPT code description has changed. Allowable charges are added periodically due to new CPT codes or updates in code descriptions.

Typically, Blue Cross reviews allowable charges for physician office injectables and administration codes twice a year, and HCPCS level II fees are reviewed annually. Notification of these updates is made through the provider newsletter or through messages on the Provider Payment Register/Remittance Advice.

Please Note: If you move to a new physical location within the state after signing your initial contract with Blue Cross, your allowable charges may be different. Blue Cross will notify you if there is a change once the necessary paperwork has been received and reviewed.

To research your allowable charges, please go to the Payments section of iLinkBlue.

NEW CODES

Blue Cross' policy for new code updates is to review the rationale for the change (e.g., AMA CPT sequencing changes, AMA language revision, new technology, etc.) and the updated Medicare fees for the new code and similar codes in comparison to the provider's current allowable charges for these similar codes to develop a fair payment for the new service.

Additional policy reviews, such as medical policy, multiple procedure reduction determination, code editing, etc. are performed. Any unusual findings/changes are reviewed with management and the medical director for final determination of allowable charges.

UNLISTED CODES

To expedite claims processing and payment, providers should submit the following information when filing unlisted codes:

- Description of service and operative report if surgery is involved.
- The comparable HCPCS/CPT code.
- Invoice if durable medical equipment (DME) is involved.
- National Drug Code (NDC) and drug name if submitting a J code or other drug code and invoice for the drug(s) billed charges on a single date.

Unlisted Professional Drug Codes

When billing J3490, J3590, J7799 and J7999 as a compound drug and a pain pump refill the reimbursement amount will be the lesser of:

- 90% of average wholesale price (AWP) of the active ingredients plus $200 compounding fee (for supplies), or
- Invoice plus 7%

If the drug is not a compound drug or a pain pump refill the reimbursement amount will be 90% of AWP.

NOT SEPARATELY REIMBURSABLE CODES

Certain codes will deny because the services these represent are included in the reimbursement of other services. Also, Blue Cross does not reimburse separately for codes such as miscellaneous codes, CPT Category II codes and most HCPCS Documentation, Measurement and Demonstration codes. These codes should not be used as a substitute for any services, unless specifically outlined in a Blue Cross billing guideline. These services are not separately reimbursed and are not billable to our members because Blue Cross considers these services to be included in other services billed for that member.

EQUIPMENT, DEVICES AND SUPPLIES

Blue Cross will not reimburse non-hospital providers for equipment, devices or supplies used in conjunction with facility inpatient or outpatient services. Reimbursement for these services is included in the facility's payment.

MEMBER COST SHARE

Deductibles, coinsurance and copayments are the member's cost share toward all services. As a participating provider, you have agreed to not waive these amounts. When the charge for an office visit is less than the member's cost share, providers should collect the actual charge. If you collect any amount above the copayment for covered services, you must refund the member the excess amount collected within 30 days of notification of the overpayment.

Participating providers have also pledged to assist us in our efforts to keep member costs down. Please be aware that members could pay higher cost shares for certain covered services performed by different types of providers and facilities. The chart below illustrates an example situation of how a member's cost share will increase if they go to an outpatient facility for services that could have been performed at a network physician's office, in-network independent lab or free-standing diagnostic imaging facility:

Example	Network Physician's Office	Network Independent Lab or Free-Standing Diagnostic Facility	Network Outpatient Facility
Charge for the covered service (i.e. low-tech X-rays, machine tests and lab work)	$300	$300	$300
Allowable charge	$200	$200	$200
Blue Cross pays	$75 (allowable charge balance)	$200 (100% Coinsurance)	$160 (80% Coinsurance)
Member pays	$25 (Copayment)	$0 (0% Coinsurance)	$40 (20% Coinsurance)