New Claims Editing Software (Professional)

Summer 2019

Today's Presenter

Mary Guy

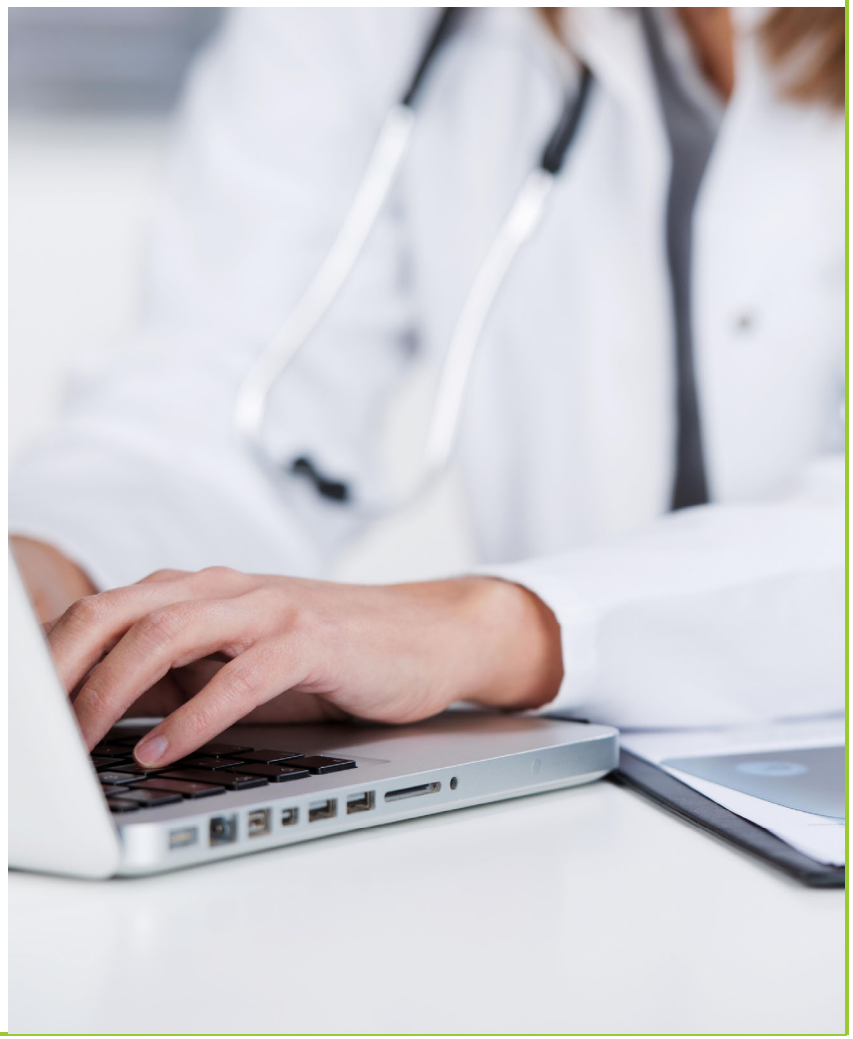
Provider Relations

New Claims Editing Software

- We are updating to a new claims editing software (CES) system
- In this webinar, we will cover what you need to know about the new software and how it may affect your claims

CES Features

- Enables us to effectively and consistently manage healthcare delivery and reimbursement by identifying potentially incorrect coding relationships on submitted claims
- Some policies have been updated based on industry-recognized rules and to be aligned closer to Medicare
- Changes will be based on a combination of national coding edits, CPT guidelines, specialty society guidelines, clinically-derived edits and federal regulations and policies governing healthcare claims



What Is It?

Claims editing that is applied to incoming claims to ensure proper coding and billing based on:

- Reimbursement
- Medical Policy
- Benefits Rules
- Industry Standard Coding Guidelines

What Does It Do?

- Promotes accurate and consistent payments
- Manages compliance with standard coding and billing practices between various types of services, such as:
  - Medical
  - Surgical
  - Lab and Radiology

What Impact Will You Notice?

- Many of the existing edits will remain the same; however, there will be some differences to conform to changes in coding standards, updated reviews of existing code editing logic and enhanced functionality of the new system
- There may be changes in your payments due to how claims are properly processed and priced as a result of this update
- This may also change the look of your payment register

When Does it Launch?

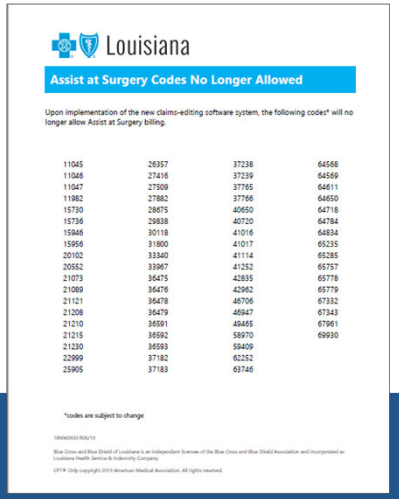
Examples of Changes

Assist at Surgery

Updated list as determined by clinical review

Billing Rules:

- Physician should bill under his/her provider number with Modifier 80, 81 or 82
- Nurse Practitioner/Physician Assistant should bill under his/her provider number with Modifier AS
- Primary physician should bill Modifier AS for CRNFA or RNFA assisting at surgery.



Louisiana

Assist at Surgery Codes No Longer Allowed

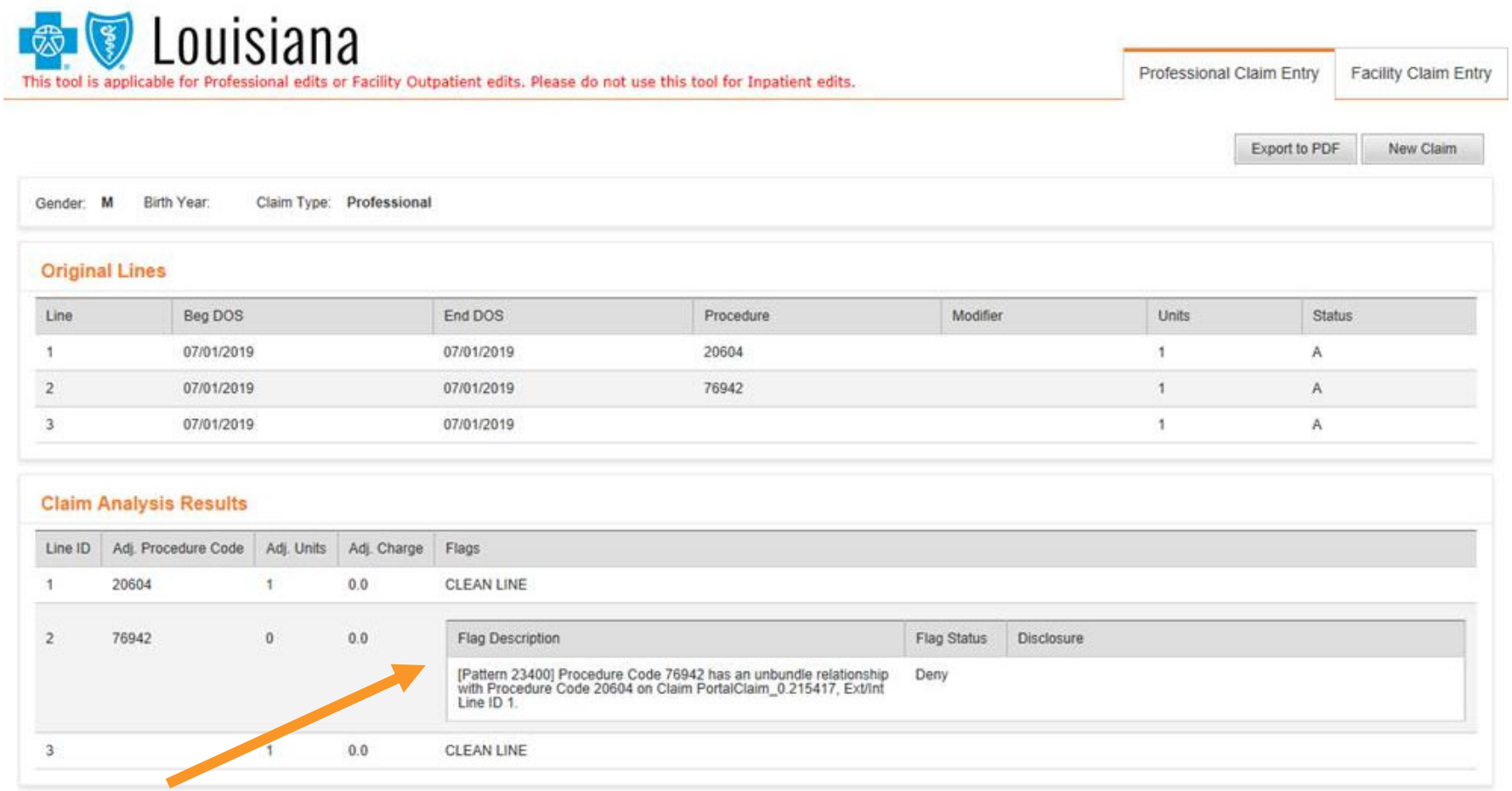
Upon implementation of the new claims-editing software system, the following codes* will no longer allow Assist at Surgery billing.

11045	26357	37238	64568
11046	27416	37239	64569
11047	27509	37765	64611
11982	27882	37766	64650
15730	28675	40650	64718
15736	29838	40720	64784
15946	30118	41016	64834
15956	31800	41017	65235
20102	33340	41114	65285
20552	33967	41252	65757
21073	36475	42835	65778
21089	36476	42962	65779
21121	36478	46706	67332
21208	36479	46947	67343
21210	36591	49465	67961
21215	36592	58970	69930
21230	36593	59409	
22999	37182	62252	
25905	37183	63746	

*codes are subject to change

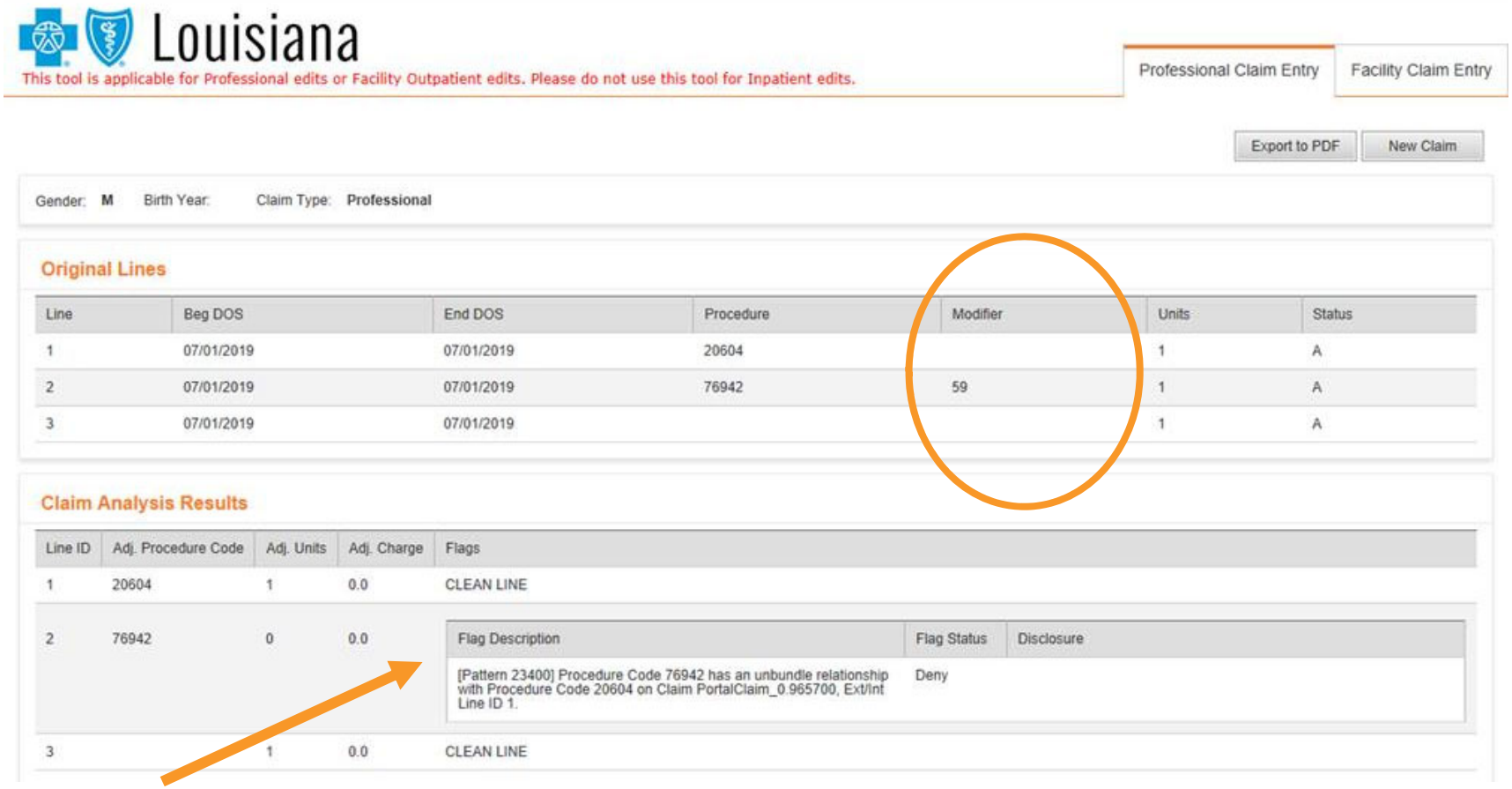
A list of codes that no longer allow Assist at Surgery billing can be found on iLinkBlue (www.BCBSLA.com/ilinkblue > Claims > Claims Editing System

Bundling, Incidental & Mutually Exclusive Edits



CPT Code 20604 - Arthrocentesis, aspiration and/or injection, with ultrasound guidance – when billed with 76942 – Ultrasonic guidance for needle placement – 76942 is included in 20604. This code pair **cannot be billed together** for any reason; therefore, modifier override is not allowed.

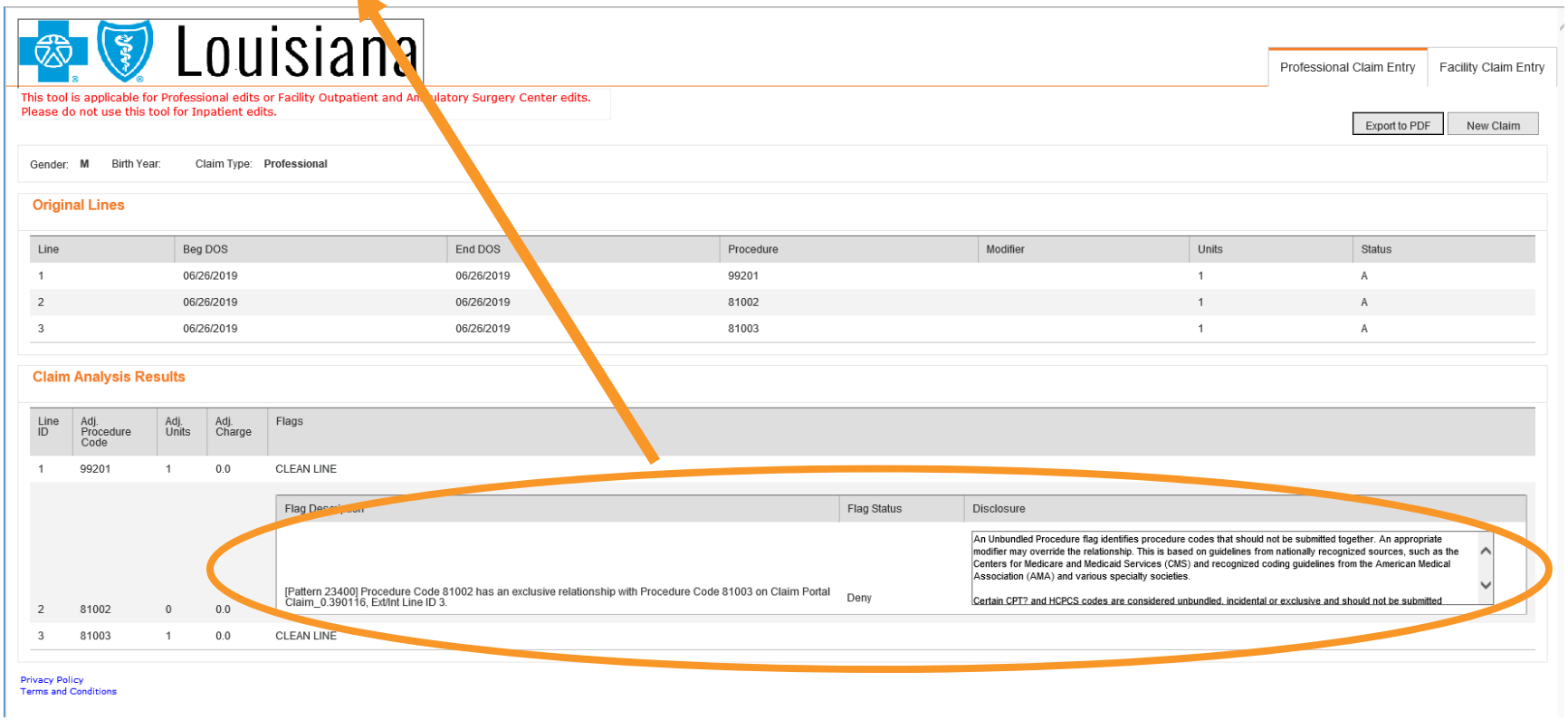
Bundling, Incidental & Mutually Exclusive Edits



CPT Code 20604 - Arthrocentesis, aspiration and/or injection, with ultrasound guidance – when billed with 76942 – Ultrasonic guidance for needle placement – 76942 is included in 20604. This code pair **cannot be billed together** for any reason; therefore, modifier override is not allowed.

Bundling, Incidental & Mutually Exclusive Edits

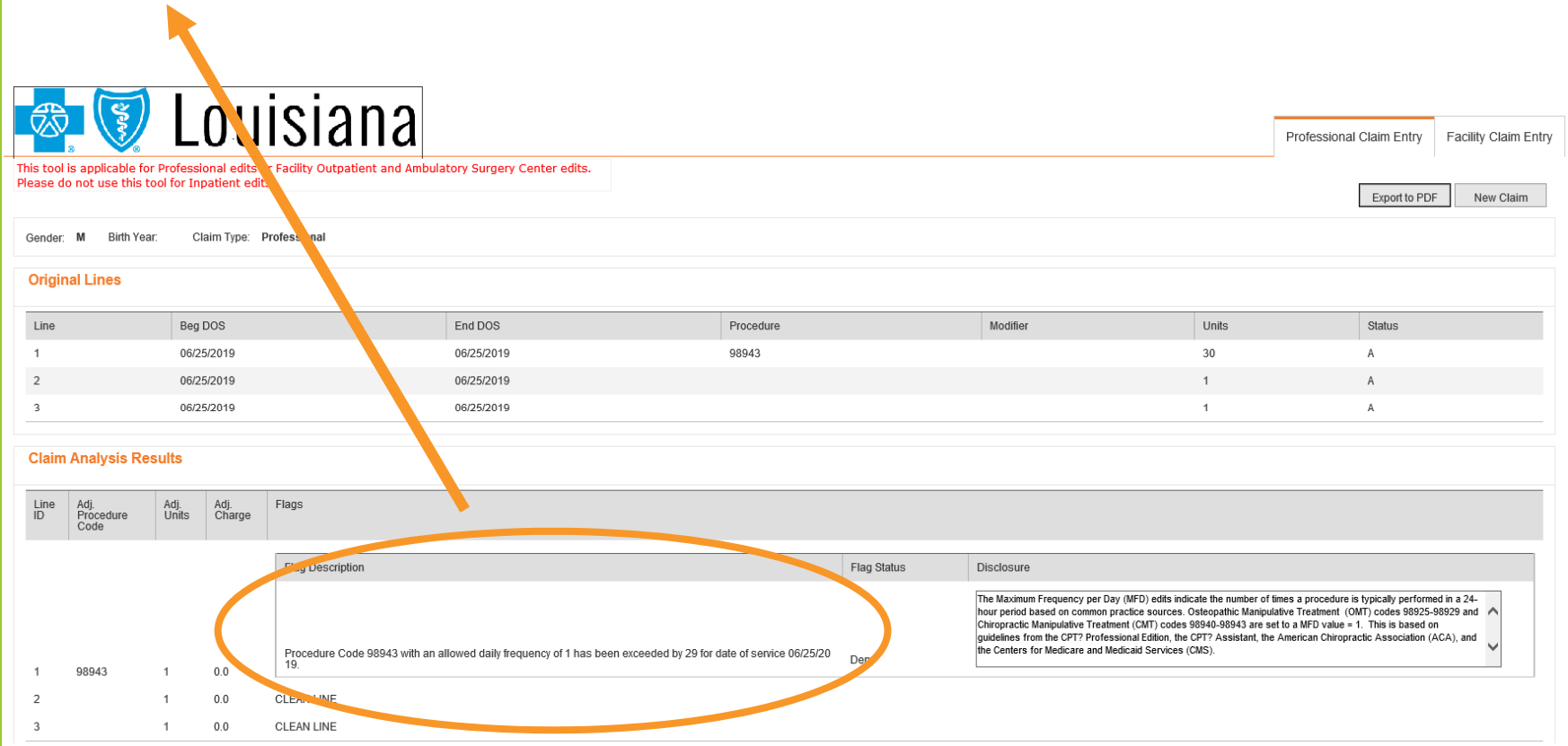
Example: Procedure Code 81002 has an exclusive relationship with Procedure Code 81003



Max Frequency

Updated list of codes and related number of units allowed on the same date of service

Example: an allowed daily frequency of 1 has been exceeded by 29



Modifiers

Updated rules applied for modifiers to be consistent with industry-recognized rules. i.e., modifiers appropriate to use with evaluation and management (E&M) codes, modifiers appropriate to use with site-specific codes, etc.

Modifier 50

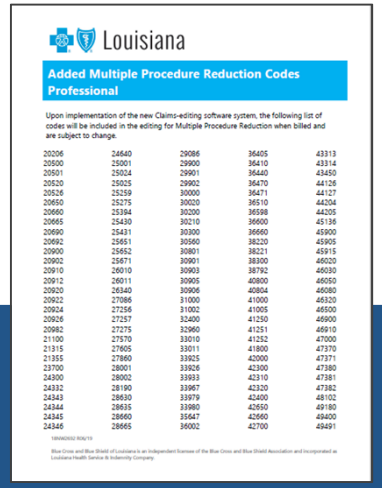
Codes that allow Modifier 50 have been updated. When billing with Modifier 50, only **one unit per line** should be billed. Additional units will be reduced to 1, and approved reimbursement will be for 1 unit only per each line.

Note: When billing multiple bilateral procedures, each would be identified and billed with Modifier 50 on separate lines, with a unit of 1 per each line

Multiple Procedure Reduction

List of additional codes where Multiple Procedure Reduction is applicable

Note: This edit is based on date of service of on and after August 1, 2019



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Added Multiple Procedure Reduction Codes Professional

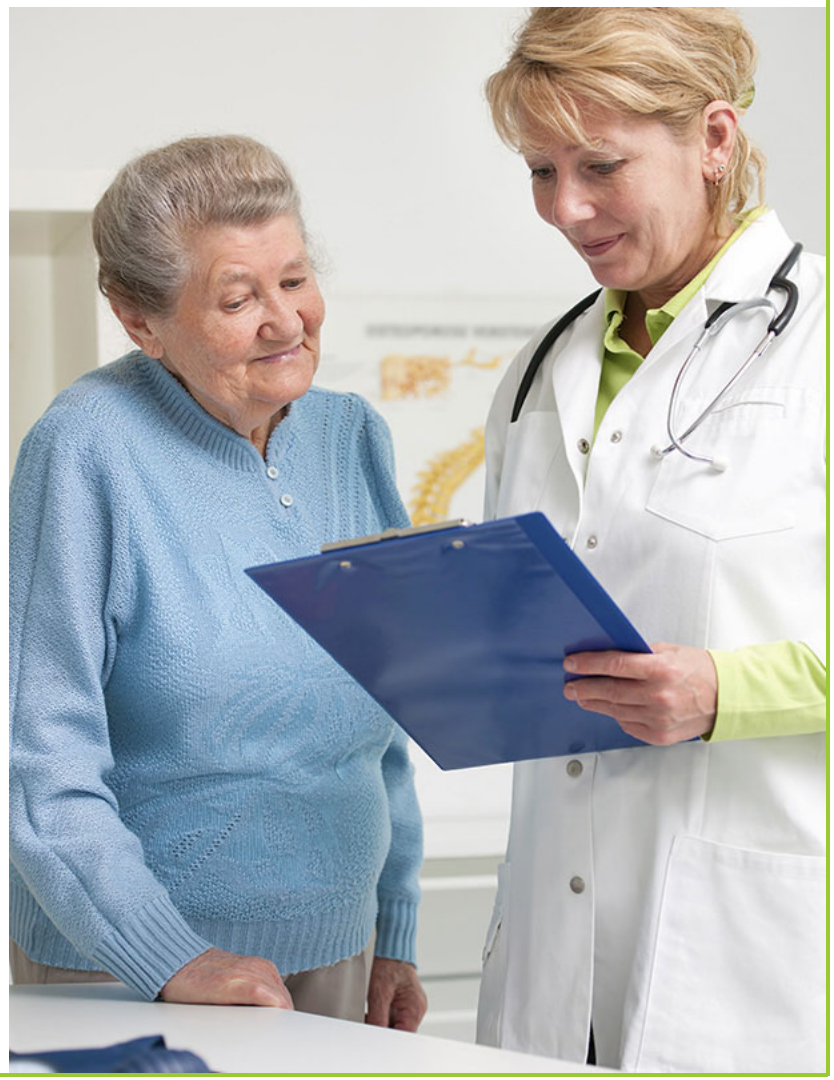
Upon implementation of the new Claims-editing software system, the following list of codes will be included in the editing for Multiple Procedure Reduction when billed and are subject to change.

20206	24640	29086	36405	43313
20500	25001	29900	36410	43314
20501	25024	29901	36440	43450
20520	25025	29902	36470	44126
20526	25259	30000	36471	44127
20650	25275	30020	36510	44204
20660	25394	30200	36598	44205
20665	25430	30210	36600	45136
20690	25431	30300	36660	45900
20692	25651	30560	38220	45905
20900	25652	30801	38221	45915
20902	25671	30901	38300	46020
20910	26010	30903	38792	46030
20912	26011	30905	40800	46050
20920	26340	30906	40804	46080
20922	27086	31000	41000	46320
20924	27256	31002	41005	46500
20926	27257	32400	41250	46900
20982	27275	32960	41251	46910
21100	27570	33010	41252	47000
21315	27605	33011	41800	47370
21355	27860	33925	42000	47371
23700	28001	33926	42300	47380
24300	28002	33933	42310	47381
24332	28190	33967	42320	47382
24343	28630	33979	42400	48102
24344	28635	33980	42650	49180
24345	28660	35647	42660	49400
24346	28665	36002	42700	49491

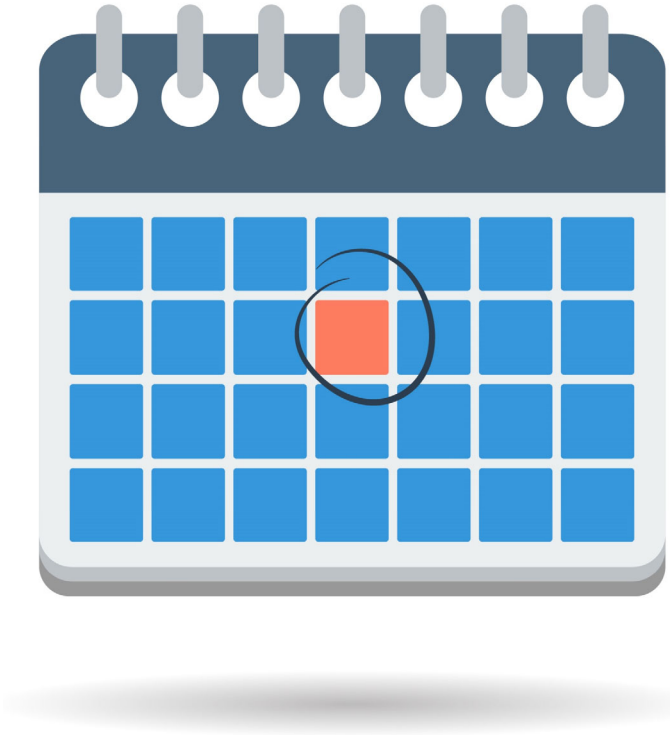
A listing of the added Multiple Procedure Reduction codes can be found on iLinkBlue (www.BCBSLA.com/ilinkblue > Claims > Claims Editing System

New Patient Visit

New visit codes, (e.g., 99201-99205), will deny if the patient has been seen by the same provider within three years from the date of the previous services



Not Separately Reimbursable



Certain codes will be denied because these services should be included with other services billed on the same day

Examples: Codes billed for general surgical supplies, quality measure codes (e.g., 0001F-9000F), HCPCS (certain H-Codes and T-Codes)

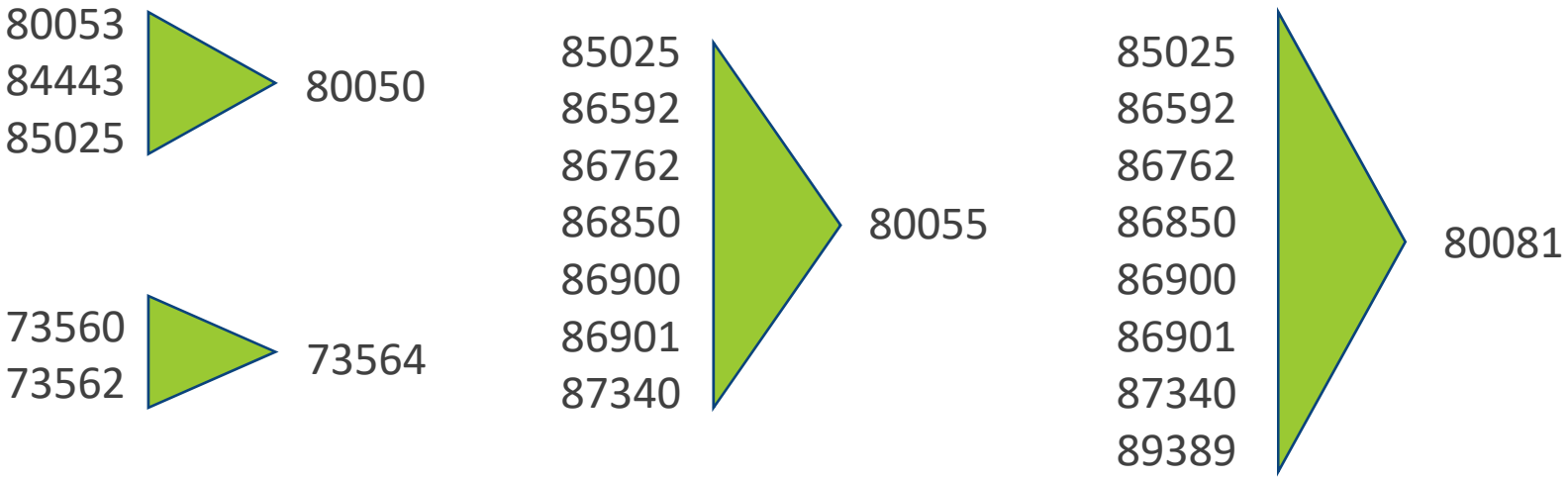
Pre- and Post-op Billing

Certain E&M codes will be denied because these services should be included in global surgical package

Rebundles

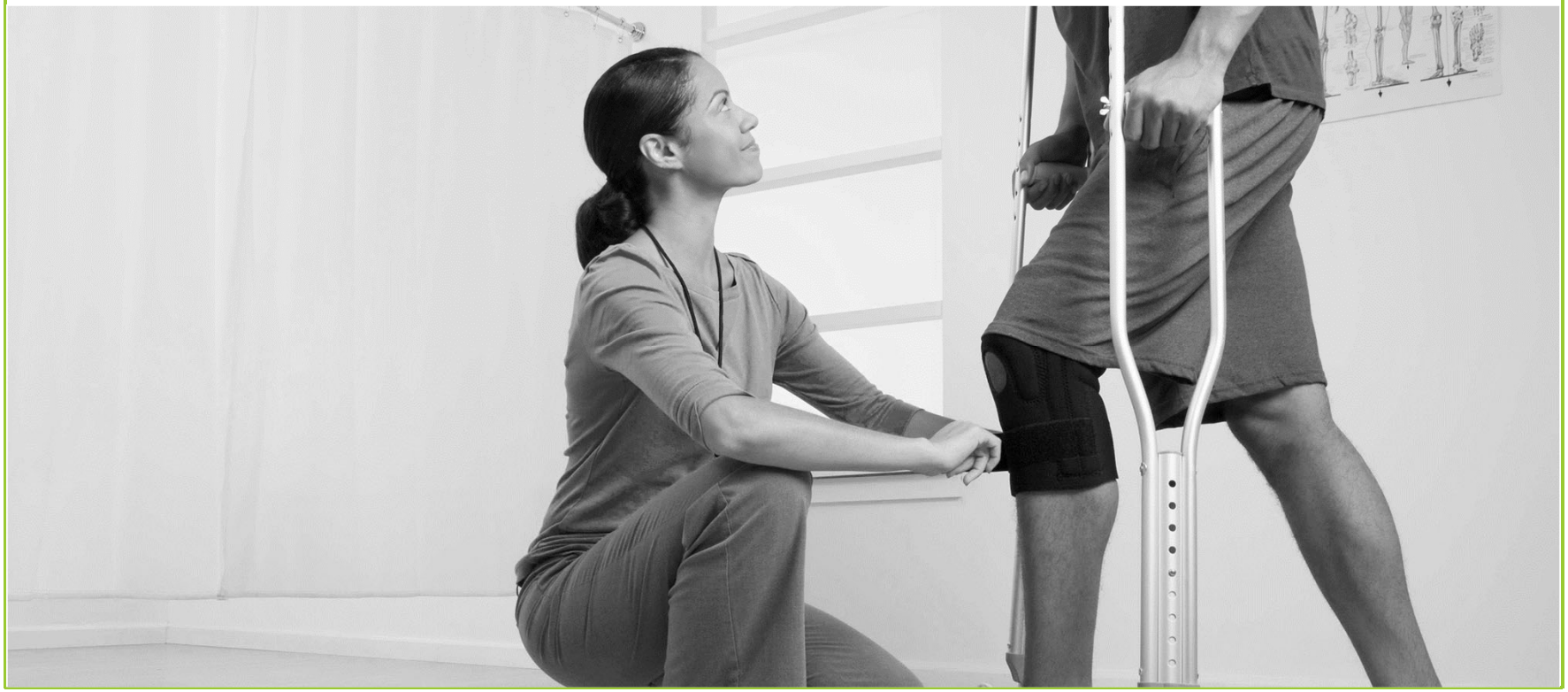
Individual lines will be denied when two or more component codes are billed instead of a more appropriate, comprehensive code. The provider will need to refile the correct, comprehensive code.

Examples:



Re-evaluations

Re-evaluations for therapy every 90 days will no longer require the appeals process



Payment Register (HIPAA 835)

Provider payment register explanation codes and associated descriptions will be different – **z45 Max Frequency**

Date: 06/24/2019

HMO LOUISIANA, INC.

WEEKLY PROVIDER PAYMENT REGISTER

Page: 1 of 1

Patient Name	Contract Number	Patient Acct	Performing Provider	Days/ Units	Admt/ Dis Dt	Claim Number	CPT4 Rev	Drg	Total Charges	Above Allow Amt	COB OC Pay	OC Code	Not Covered Ded-Coin-Inel	Amount Paid
				1			9894059		$50.00	$28.01	$0.00		$21.99	$0.00
										$28.01 PXN-CO			$21.99 CPY-PR	
				1			G028359		$20.00	$5.86	$0.00		$8.01	$6.13
										$5.86 PXN-CO			$8.01 CPY-PR	
				1			G028359		$20.00	$20.00	$0.00		$0.00	$0.00
										$20.00 z45-CO				
				1			99070		$65.00	$0.00	$0.00		$65.00	$0.00
													$65.00 345-PR	
				1			99070		$65.00	$0.00	$0.00		$65.00	$0.00
													$65.00 345-PR	
Totals:				5					$220.00	$53.87	$0.00		$160.00	$6.13

CO - This Amount is determined by Blue Cross to be the responsibility of the Provider.
PR - This is the amount determined by Blue Cross to be the responsibility of the Patient.
PXN - The charge exceeds the allowed amount for this service.
CPY - Copay
345 - This service is not covered under the member's contract.
z45 - Some or all units exceeded the maximum daily allowed amount.

REMEMBER: To ensure continued prompt and accurate processing of your claims, please file your claims using your National Provider Identifier on and after May 23, 2008. The NPI must be given to BCBS as soon as possible to be entered into our system. We will not accept notification of the NPI through your claims. For questions about the NPI call 1-800-716-2299. option 3 or visit our website, www.bcbsla.com

Payment Register (HIPAA 835)

Provider payment register explanation codes and associated descriptions will be different – **p07 max frequency exceeded**

Date: 06/24/2019

BLUE CROSS BLUE SHIELD OF LOUISIANA

WEEKLY PROVIDER PAYMENT REGISTER

Page: 3 of 3

Patient Name	Contract Number	Patient Acct	Performing Provider	Days/ Units	Admt/ Dis Dt	Claim Number	CPT4 Rev	Drg	Total Charges	Above Allow Amt	COB OC Pay	OC Code	Not Covered Ded-Coin-Inel	Amount Paid
				1	5/13/2019 5/13/2019		97110GP		$60.00	$31.56	$0.00		$5.68	$22.76
										$31.56 PXN-CO			$5.68 COI-PR	
				3	5/13/2019 5/13/2019		97113GP		$150.00	$46.26	$0.00		$20.74	$83.00
										$46.26 PXN-CO			$20.74 COI-PR	
				1	2/5/2019 2/5/2019		97164		$125.00	$125.00	$0.00		$0.00	$0.00
										$125.00 p07-CO				
				1	3/3/2019 3/3/2019		97164		$30.00	$30.00	$0.00		$0.00	$0.00
										$30.00 p07-CO				
Totals:				34					$1,787.00	$1,018.74	$0.00		$153.55	$614.71

CO - This Amount is determined by Blue Cross to be the responsibility of the Provider.
PR - This is the amount determined by Blue Cross to be the responsibility of the Patient.
PXN - The charge exceeds the allowed amount for this service.
COI - Coinsurance
p07 - The units have exceeded the allowable maximum frequency per time span. Maximum daily occurrence of procedure or service.

REMEMBER: To ensure continued prompt and accurate processing of your claims, please file your claims using your National Provider Identifier on and after May 23, 2008. The NPI must be given to BCBS as soon as possible to be entered into our system. We will not accept notification of the NPI through your claims. For questions about the NPI call 1-800-716-2299. option 3 or visit our website, www.bcbsla.com

Important Things to Remember

- Most edits are based on date processed, **not** date of service*
- Any claim adjustments processed **after the implementation date** of the new CES system will be subject to edits in the new system
- **Explanation codes and descriptions** on payment register may be different in the new system

*With the exception of Multiple Procedure Reductions

Troubleshooting

If you do not understand the way your claim was processed follow these steps to troubleshoot

Troubleshooting

Step 1

Check that you are following the proper billing guidelines. Refer to resources in your:

- Provider Manual
- Code Book
- Lists provided on iLinkBlue, etc.

Step 2

Check the new CES provider portal tool to determine if the CES system is processing according to the new edits based on the rejection code. (CES edits will appear in lower case.)

How to Inquire

Step 3

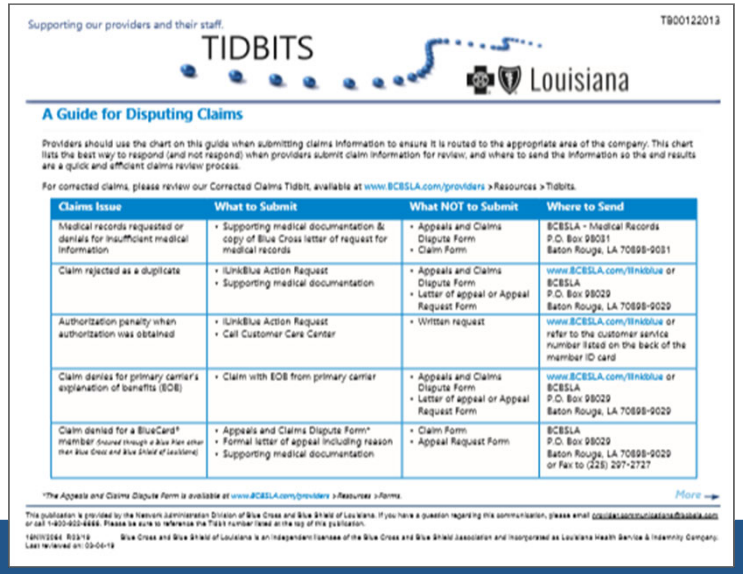
Submit an Action Request

- In order to properly route your inquiry please choose "**Code Editing Inquiry**" from the action drop down box when submitting your action request
- Please include your contact information
- Be specific and detailed
- Allow up to 15 working days for a response to each request
- Check in "Action Request Inquiry" for a response
- A second request may be submitted if there was no resolution

How to Inquire

Step 4

Review the "**A Guide for Disputing Claims**" tidbit for proper steps in order to dispute a claim



Supporting our providers and their staff.

T900122013

TIDBITS

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A Guide for Disputing Claims

Providers should use the chart on this guide when submitting claims information to ensure it is routed to the appropriate area of the company. This chart lists the best way to respond (and not respond) when providers submit claim information for review, and where to send the information so the end results are a quick and efficient claims review process.

For corrected claims, please review our Corrected Claims Tidbit, available at www.BCBSLA.com/providers >Resources >Tidbits.

Claims Issue	What to Submit	What NOT to Submit	Where to Send
Medical records requested or denials for insufficient medical information	• Supporting medical documentation & copy of Blue Cross letter of request for medical records	• Appeals and Claims Dispute Form • Claim Form	BCBSLA - Medical Records P.O. Box 98031 Baton Rouge, LA 70898-9031
Claim rejected as a duplicate	• iLinkBlue Action Request • Supporting medical documentation	• Appeals and Claims Dispute Form • Letter of appeal or Appeal Request Form	www.BCBSLA.com/ilinkblue or BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029
Authorization penalty when authorization was obtained	• iLinkBlue Action Request • Call Customer Care Center	• Written request	www.BCBSLA.com/ilinkblue or refer to the customer service number listed on the back of the member ID card
Claim denies for primary carrier's explanation of benefits (EOB)	• Claim with EOB from primary carrier	• Appeals and Claims Dispute Form • Letter of appeal or Appeal Request Form	www.BCBSLA.com/ilinkblue or BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029
Claim denied for a BlueCard® member (insured through a Blue Plan other than Blue Cross and Blue Shield of Louisiana)	• Appeals and Claims Dispute Form* • Formal letter of appeal including reason • Supporting medical documentation	• Claim Form • Appeal Request Form	BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029 or Fax to (225) 297-2727

*The Appeals and Claims Dispute Form is available at www.BCBSLA.com/providers >Resources >Forms.

More

This publication is provided by the Network Administration Division of Blue Cross and Blue Shield of Louisiana. If you have a question regarding this communication, please email provider.communications@bcbsla.com or call 1-800-922-6666. Please be sure to reference the TIDBIT number listed at the top of this publication.

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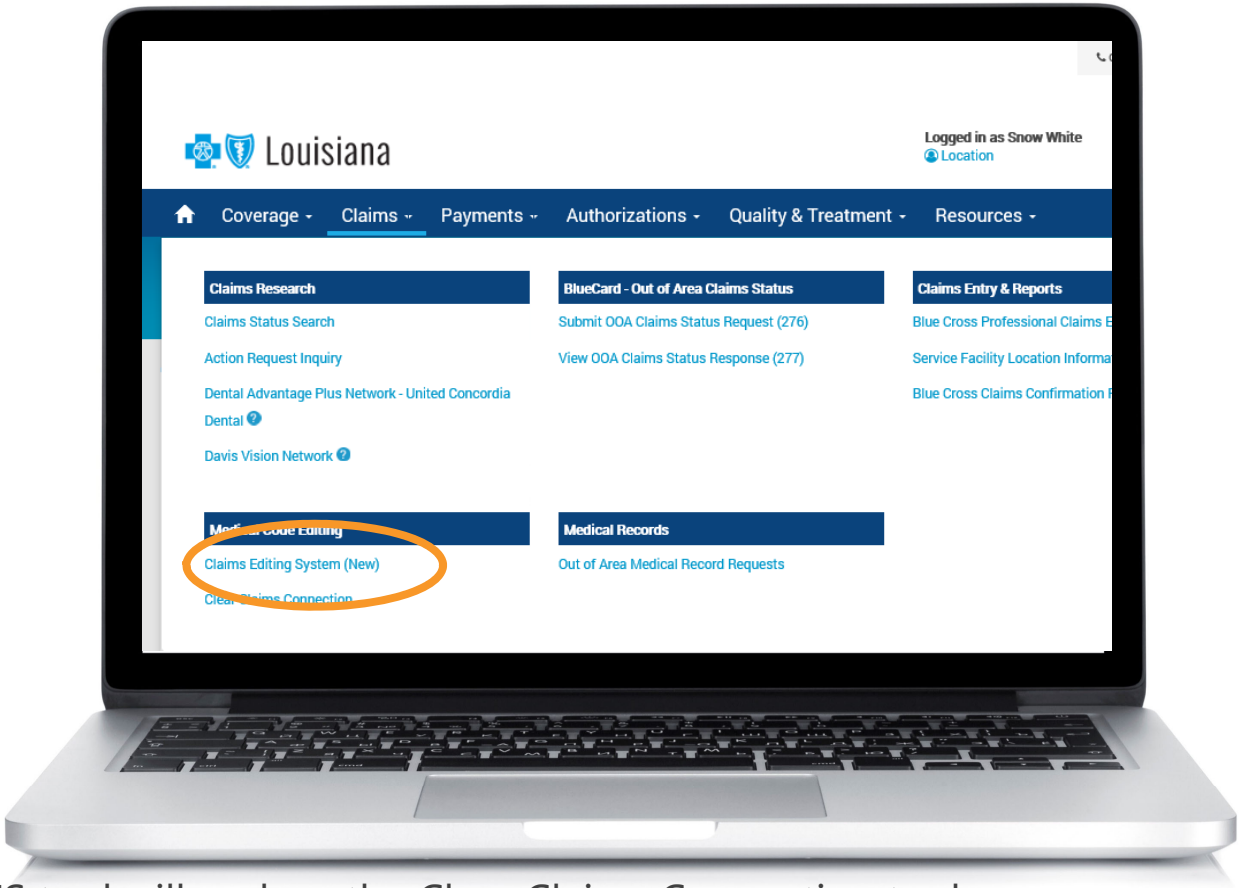
Last reviewed on: 03-04-19

www.BCBSLA.com/providers >Resources >Tidbits

New CES Provider Portal Tool

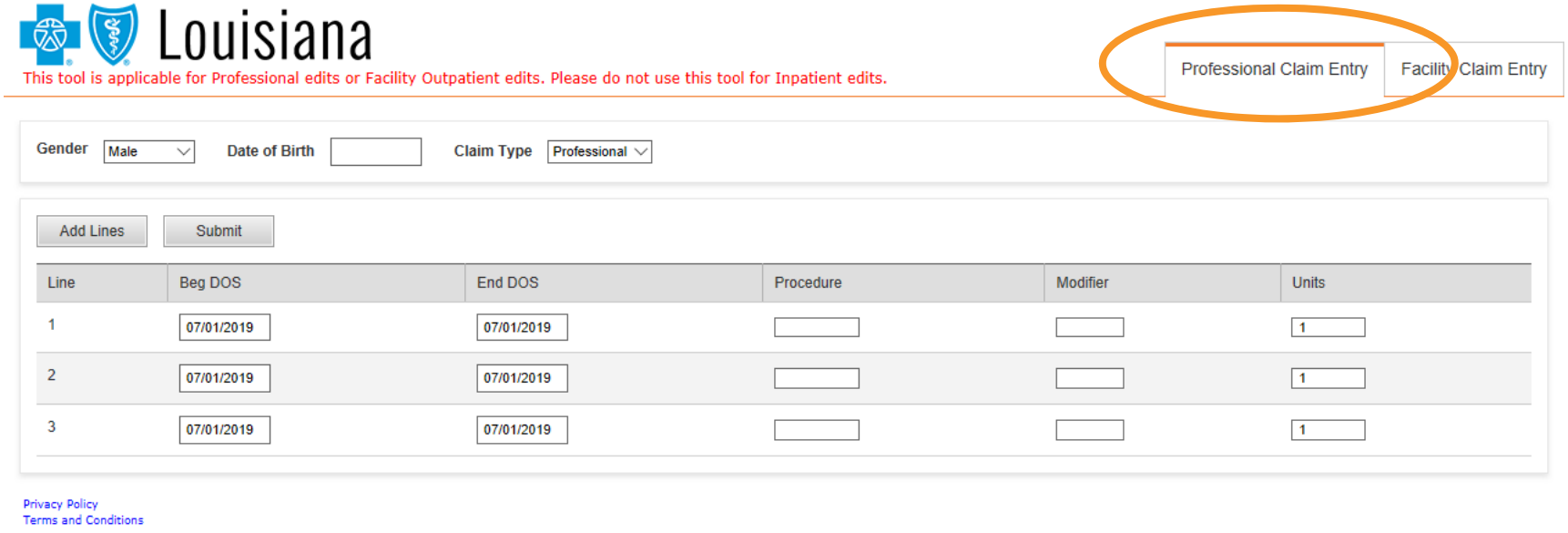
With the implementation of the new CES system, we have a new tool in iLinkBlue for providers to calculate claim edit outcomes



This new CES tool will replace the Clear Claims Connection tool

CES Provider Portal Tool

The new CES tool is available for both **professional** and **outpatient facility** claims. Please make sure you select the correct tab as the edits and modifiers will not be the same.



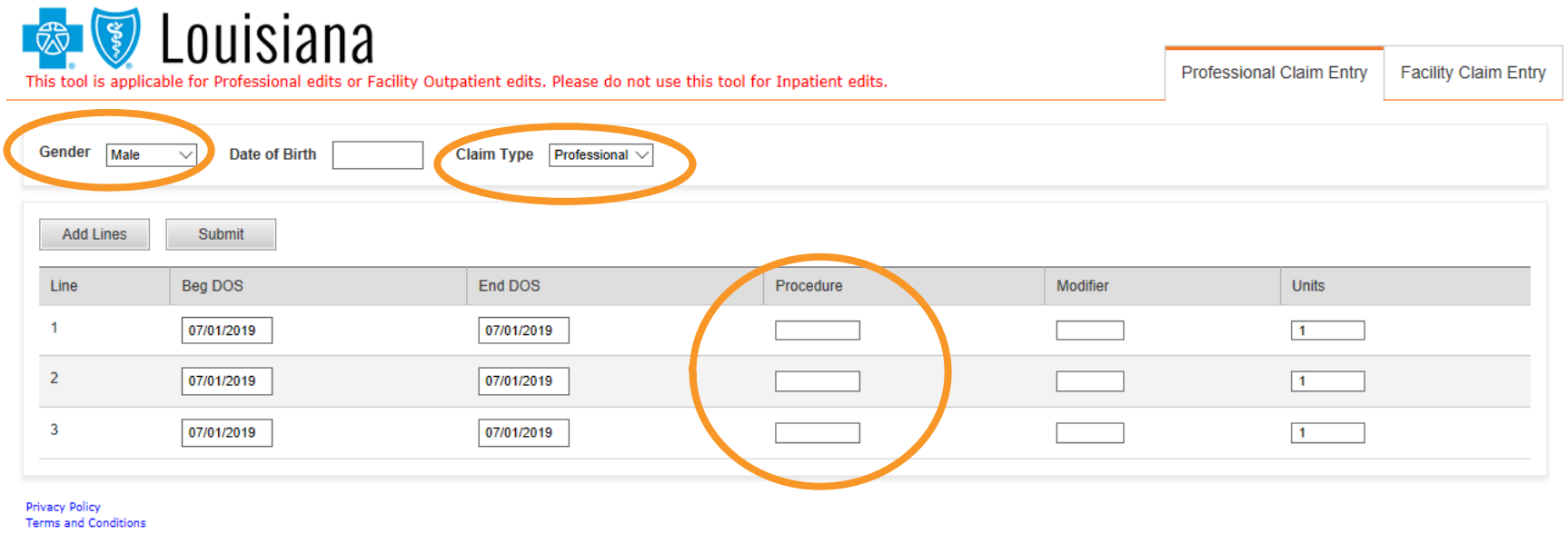
CES Provider Portal Tool

This tool applies to **professional** and does not guarantee claims payment.

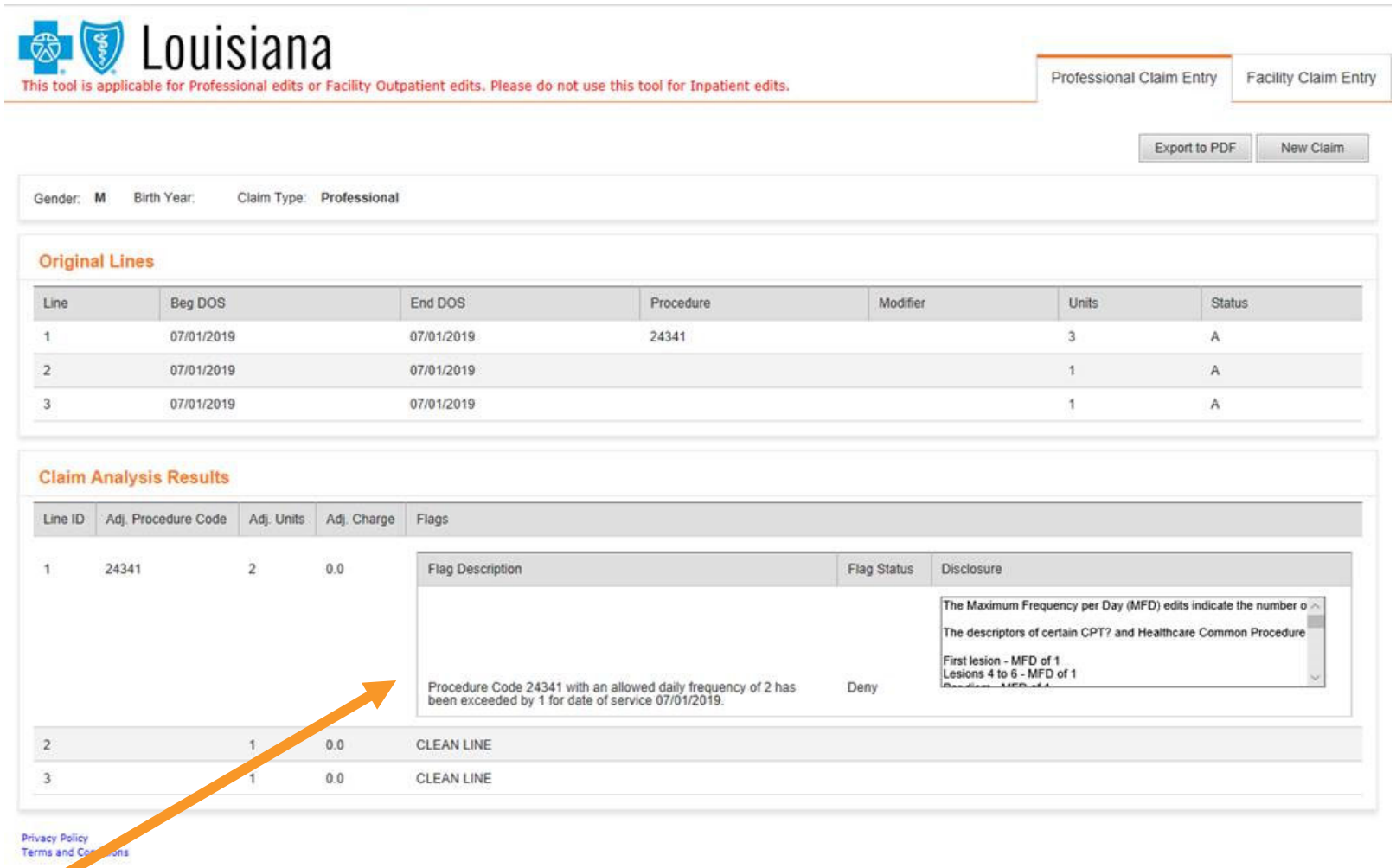
The results of the software do not consider all circumstances and factors that may affect payment including:

- Historical claims previously billed
- Units billed
- Global day edits for procedures
- Multiple procedure reduction
- Member benefits and eligibility
- Provider contracts
- Modifiers that override edits

CES Provider Portal Tool Mandatory Fields



CES Provider Portal Tool Outputs



CPT Code 24341 – Repair, tendon or muscle, upper arm or elbow daily max frequency limit of 2 units. Code on one line with 3 units – 2 units will pay, 1 unit will deny.

CES Provider Portal Tool Outputs

Louisiana

This tool is applicable for Professional edits or Facility Outpatient edits. Please do not use this tool for Inpatient edits.

Professional Claim Entry | Facility Claim Entry

Export to PDF | New Claim

Gender: **M** Birth Year: Claim Type: **Professional**

Original Lines

Line	Beg DOS	End DOS	Procedure	Modifier	Units	Status
1	07/01/2019	07/01/2019	25246		2	A
2	07/01/2019	07/01/2019			1	A
3	07/01/2019	07/01/2019			1	A

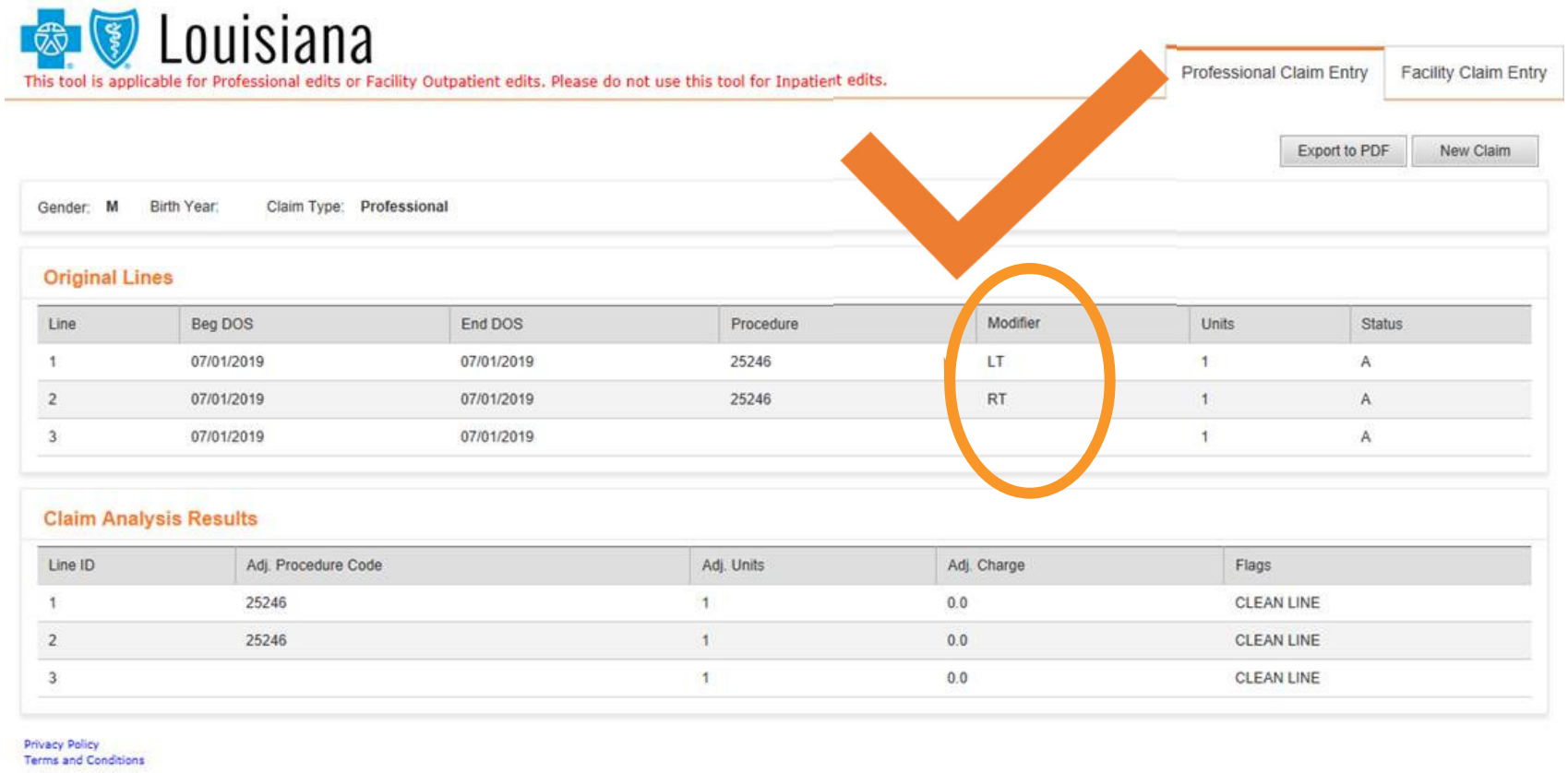
Claim Analysis Results

Line ID	Adj. Procedure Code	Adj. Units	Adj. Charge	Flags
1	25246	1	0.0	
2		1	0.0	CLEAN LINE
3		1	0.0	CLEAN LINE

Flag Description	Flag Status	Disclosure
Procedure Code 25246 with an allowed daily frequency of 1 has been exceeded by 1 for date of service 07/01/2019.	Deny	The Maximum Frequency per Day (MFD) edits indicate the number o The descriptors of certain CPT? and Healthcare Common Procedure First lesion - MFD of 1 Lesions 4 to 6 - MFD of 1

CPT Code 25246 – Injection procedure for wrist daily max frequency limit of 1 unit. Code on one line with 2 units – 1 unit will pay and one unit will deny.

CES Provider Portal Tool Outputs



Louisiana

This tool is applicable for Professional edits or Facility Outpatient edits. Please do not use this tool for Inpatient edits.

Professional Claim Entry | Facility Claim Entry

Export to PDF | New Claim

Gender: M Birth Year: Claim Type: Professional

Original Lines

Line	Beg DOS	End DOS	Procedure	Modifier	Units	Status
1	07/01/2019	07/01/2019	25246	LT	1	A
2	07/01/2019	07/01/2019	25246	RT	1	A
3	07/01/2019	07/01/2019			1	A

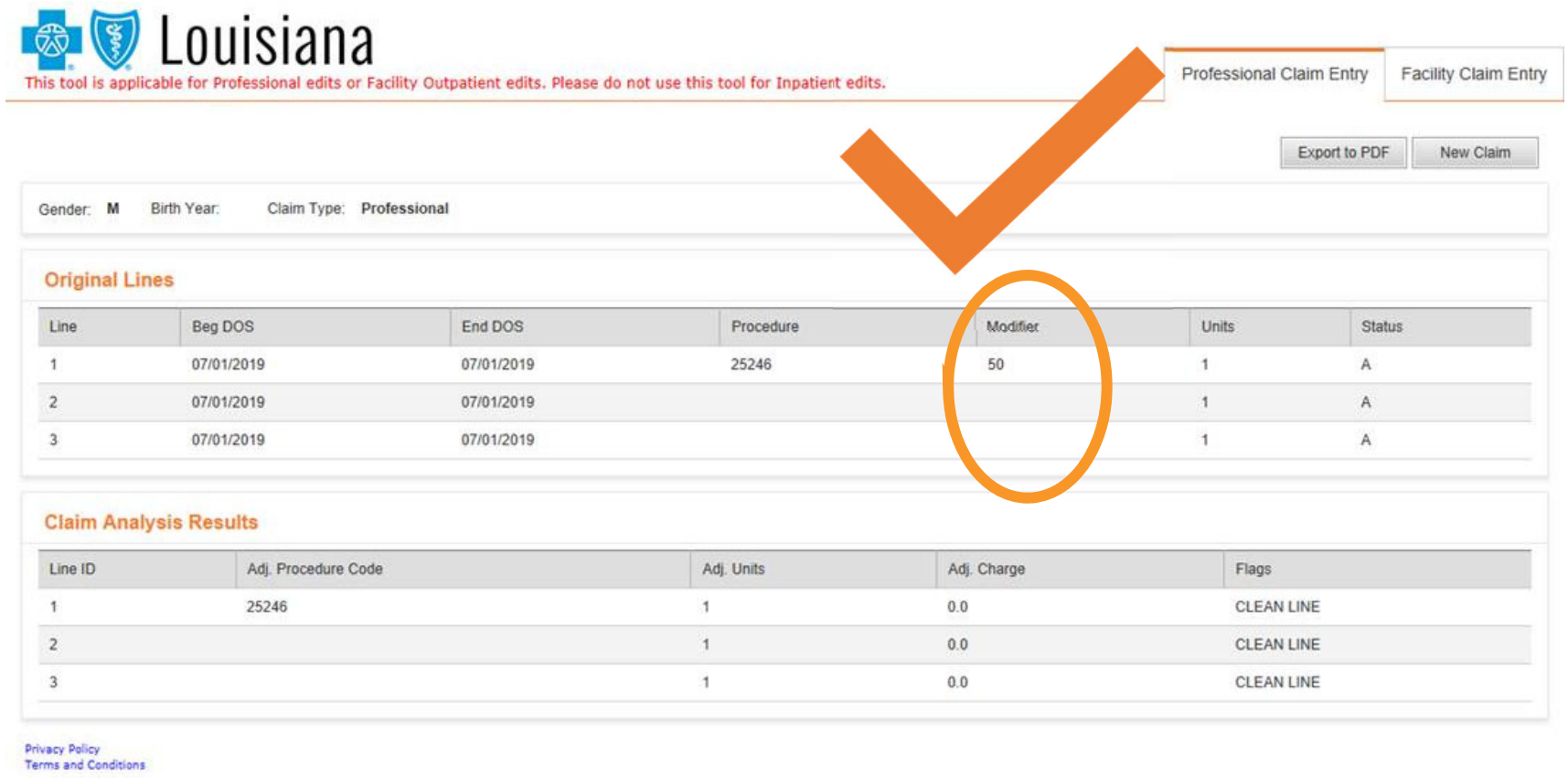
Claim Analysis Results

Line ID	Adj. Procedure Code	Adj. Units	Adj. Charge	Flags
1	25246	1	0.0	CLEAN LINE
2	25246	1	0.0	CLEAN LINE
3		1	0.0	CLEAN LINE

Privacy Policy
Terms and Conditions

CPT 25246 (injection procedure) – billed correctly with Modifiers LT, RT and one unit, it will pay correctly

CES Provider Portal Tool Outputs



CPT 25246 (injection procedure) – billed correctly with Modifier 50

Questions?

If you have additional questions after this webinar, please email provider.relations@bcbsla.com.