PROVIDER BULLETIN
PROVIDER INFORMATION

BlueCross BlueShield Minnesota

September 4, 2018

New Payment Policy Auditing System

Effective October 19, 2018, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be enhancing the claims editing system to ensure claims are coded to the highest level of specificity to allow for proper payment. The edits used will be consistent with the expectations outlined in the Blue Cross Provider Policy and Procedure Manual and utilizes the Centers for Medicare & Medicaid (CMS), the American Medical Association (AMA) and other specialty academy policies and procedures; as well as proprietary Blue Cross plan specific requirements.

Areas of Focus

Blue Cross requires the correct use of all modifiers covered under CPT, CMS, and National Correct Coding Initiative (NCCI) guidelines, including but not limited to:

- Modifier GN, GO, GP
- Modifier 91
- Anatomic Modifiers
- Correct use of a modifier in combination with Medicare column 1 column 2
- Alignment of modifier to professional service

As a reminder the primary diagnosis must be present on all claims in accordance with ICD 10 coding guidelines.

Examples of Automated Claim Edits:

Please note, the scope of the edits implemented is not limited to the following examples; the examples are to illustrate the types of correct coding expectations that are in place in the enhanced system.

Modifier GN, GO, GP

Rehabilitative therapies that are submitted for Medicare Advantage plan subscribers without the appropriate modifier will be denied with the claim adjustment reason code of 4, "The procedure code is inconsistent with the modifier used or a required modifier is missing."

The use of one of the three therapy modifiers (GN, GO, or GP) is required on a certain set of Healthcare Common Procedure Coding System (HCPCS) codes to identify when each OPT service is furnished under an SLP, OT, or PT plan of care.

Modifier 91

Repeat lab services require modifier 91 (not 59) unless the narrative supports submission of multiple units.

Modifier 91 should not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required.

Continued

Anatomic Modifiers
Certain procedures require an anatomical modifier (fingers, toes, eyelids, coronary arteries, right, left and bilateral). When an anatomic modifier is not appended, the procedure will be denied. Anatomic modifiers must match the anatomic diagnosis. A CPT code for a fracture of the right ankle (modifier RT) must align to the diagnosis code, reflecting the same anatomic appendage/extremity.

NCCI
Immunization administration (90471) when billed in combination with 99213 (office or another outpatient visit for E&M of an established patient) would require a modifier 25 on the E&M, otherwise would deny.

Immunization administration (90471) includes: percutaneous, intradermal, subcutaneous, or intramuscular injections; 1 vaccine (single or combination vaccine/toxoid).

Reference material for NCCI can be found at the following location:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf

ICD Coding Guidelines
ICD manual guidelines state that chemotherapy, immunotherapy, and radiation administration must be billed using the primary or principal diagnosis, in these instances the Z code should be the principle diagnosis followed by the malignancy diagnosis.

Global, Technical, Professional Policy
According to CMS, codes with a PC/TC Indicator of "9" cannot be split into professional components (modifier 26) and technical components (modifier TC) as the concept of PC/TC does not apply. Therefore, when these services are billed with modifiers 26 or TC, they will be denied.

Impacted Lines of Business
Commercial fully insured, self-insured and individual plans, as well as Medicare Advantage products are included. ITS, Federal Employee Program (FEP), and Medicaid are not in scope at this time.

Questions?
If you have questions, please contact provider services at **(651) 662-5200** or **1-800-262-0820**.