MEDICAID REIMBURSEMENT POLICY

Code Editing

Active

Section: General Coding
Policy Number: 003
Effective Date: 04/01/24

Description

This policy addresses the coding edits utilized by Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) to assist in a consistent claim review process.

Policy Statement

Blue Cross uses code edits to help expedite and improve the accuracy of processing claims.

The procedure code edits are based on Current Procedural Terminology (CPT®) guidelines, a review of the Center for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI) policies and guidelines, Minnesota Administrative Uniformity Committee (AUC), specialty society guidelines, and agreed upon industry practices. This automated review process is designed to apply the same industry criteria consistently across claims. Below are general code editing guidelines used by Blue Cross, this is not all inclusive.

Add-On Codes

Add-on codes describe procedures or services that are always provided “in addition to” other, related services or procedures. Add-on codes cannot stand alone as separately reportable services.

For example, certain CPT codes for the integumentary system indicate a second or third lesion. These codes are add-on codes and should only be reported with the primary code for the first lesion.

NCCI Procedure-to-Procedure (PTP) Edits

These edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column One and Column Two HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same member on the same date of service, the Column One code is eligible for payment, but the Column Two code is denied unless a clinically appropriate NCCI PTP-associated modifier is allowed and reported.

Procedure Code Unbundling/Rebundling

Procedure code unbundling is the submission of multiple procedure codes for a group of specific procedures that are components of a single comprehensive code. Procedure unbundling may occur in one of two ways:

- A professional claim could be submitted that has procedure codes for both the individual components and the comprehensive procedure. Blue Cross would rebundle the individual component codes into the comprehensive procedure code for payment.

- Procedure unbundling could also occur when a professional claim is submitted with only the individual components of the comprehensive code. In this situation, the system will recognize the relationship between the comprehensive code and its individual components. Then, it will automatically add the comprehensive code to the claim and rebundle the individual components into that comprehensive code for payment.

Mutually Exclusive Procedures
Mutually exclusive procedures exist when a claim is submitted for two or more procedures that are not usually performed on the same patient on the same date of service. In mutually exclusive relationships, the most clinically intense code is recognized for payment. Clinical intensity is generally based on the total RVU for the procedures submitted. This edit would result in the line item denial of the least clinically intense code as provider liability.

Distinct Procedural Services
Modifiers –59, XE, XS, XP, or XU may be appended to non-E/M procedures/services that are not normally reported together but are appropriate under the circumstances.

Incidental Procedures
Incidental is defined as a procedure carried out at the same time as a primary procedure but is clinically integral to the performance of the primary procedure, and therefore, should not be separately reimbursed. This edit would result in the line item denial of the incidental code as provider liability.

Medical and Surgical Supplies
Medical and surgical supplies during an outpatient or physician office visit are included as incidental to the E/M service or procedure performed and will not be separately reimbursed.

Medical Visits on the Same Day as Surgery
Refer to *Medicaid General Coding – 007 Global Surgical Package Reimbursement Policy*

Global Surgical Package – Pre- and Postoperative Services
Refer to *Medicaid General Coding – 007 Global Surgical Package Reimbursement Policy*

Reduced or Discontinued Services
Append the –52 modifier to indicate that a service or procedure is partially reduced or eliminated at the physician's discretion. This provides a means of reporting reduced services without altering the identification of the basic service. Blue Cross will pay the lesser of either 50% of the physician fee schedule allowance for the procedure or the charge submitted.

Append the –53 modifier when a physician or other qualified healthcare professional elects to terminate a surgical or diagnostic procedure due to extenuating circumstances that threaten the well-being of the patient. Blue Cross will pay the lesser of either 50% of the physician fee schedule allowance for the procedure or the charge submitted.

Append -73 modifier to outpatient hospital/Ambulatory Surgery Center (ASC) procedures discontinued *prior* to the administration of anesthesia. The intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of the modifier -73. Blue Cross will reimburse the lesser of either 50% of the allowed amount or the charge submitted.

Append -74 modifier to outpatient hospital/Ambulatory Surgery Center (ASC) procedures discontinued *after* the administration of anesthesia. The intended service that is prepared for but cancelled can be reported by its usual procedure code and the addition of the modifier -74.

Units of Service Validation and Restriction
Blue Cross requires each service to be submitted with the appropriate unit of measurement. Refer to Appendix A, Section A.3.2 Units, of the AUC Minnesota Uniform Companion guide for reporting units.

The number of units for codes that qualify for submission of multiple units may be subject to limits. Refer to *Medicaid General Coding – 009 Maximum Units Per Day Reimbursement Policy.*

National Drug Code (NDC) Numbers
A valid 11-digit NDC number, NDC unit of measurement, and NDC units dispensed is required on professional (837P) and outpatient institutional (837I) electronic claim transactions for reimbursement of physician-administered drugs. The NDC must match the valid HCPCS code submitted for the medical drug.

NDCs must be reported using the "5-4-2 format". If a drug's NDC does not follow this format, then a zero must be inserted at the beginning of the appropriate section of the number, to create the 5-4-2 format.

These edits will occur in the pre-adjudication phase of processing. If the claim submission does not pass (or fails for invalid or 10-digit codes) it will stop and be rejected back to the provider.

This rejection occurs before the submission is accepted as a claim; therefore, a claim number is not assigned and the provider must correct the data and resubmit all charges. There will not be any duplicate editing or adjustments, because a claim was not created in the payer adjudication system.

Modifier Compatibility
Modifiers are subject to compatibility edits with the procedure to which they are appended. For example, an Evaluation and Management (E/M) service appended with a -59 modifier will be denied.

Diagnosis Coding
If the supporting diagnosis code is not linked to the procedure code, the primary diagnosis will be used to support all the services rendered, which may result in benefits being denied or processed incorrectly for individual procedures.

Patient Billing Impact
The patient is not responsible and must not be balance billed for any procedures for which payment has been denied or reduced by Blue Cross as the result of a coding edit. Edit denials are designed to ensure appropriate coding and to assist in processing claims accurately and consistently.

BlueCross BlueShield Minnesota

Coding Appeals

Blue Cross' coding edits are updated at minimum annually, to incorporate new codes, code definition changes, and edit rule changes. All claims submitted after the implementation date of these changes, regardless of service date, will be processed according to the updated change(s). No retrospective payment changes, adjustments, and/or request refunds will be made when processing changes are a result of new code editing rules.

Blue Cross has adopted a standard process to review edit appeals and providers have the right to appeal with additional information. If you have a question or appeal about our policy regarding a particular coding combination, provide a written statement of the concern, along with the following information and/or documentation normally required for a medical review.

- Written explanation supporting the procedures submitted, for example, specific references, specialty specific criteria
- Documentation from a recognized authoritative source that supports your position on the procedure codes submitted. Once received, the inquiry or appeal will be reviewed and if necessary, forwarded to the medical review department for determination. The review may result in approval or denial of the claim, based on review of the information submitted.

If your claim is denied due to lack of documentation to support the use of a specific modifier or an invalid modifier/procedure combination, you may submit a claim payment appeal or replacement claim. Your appeal must be in writing and accompanied by the necessary documentation. Replacement claims must include an attachment with supporting documentation.

- **Note:** Requests to add modifiers 24, 25, 57, 59, XE, XP, XS, XU to a denied service must follow the replacement claim process. Replacement claims submitted without medical records will be denied and the original claims will remain as originally processed.

Documentation Submission

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

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

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 current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

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

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	24	25	52	53	57	59	73
	74	XE	XP	XS	XU		
ICD-10 Diagnosis:	N/A						
ICD-10 Procedure:	N/A						
CPT/HCPCS:	N/A						
Revenue Codes:	N/A						

Resources

Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)
Medicare National Correct Coding Initiative (NCCI) Edits
Minnesota Administrative Uniformity Committee (AUC) Companion Guides

Policy History

08/22/2023	Initial Committee Approval
01/23/2024	Annual Policy Review

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