SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.9 CODE EDITING

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.

CODE EDITING

Claims-editing System

Claims-editing software allows for effective and consistent management of health care billing and reimbursement by identifying potentially incorrect coding relationships on submitted claims. System changes are based on a combination of national coding edits, CPT guidelines, specialty society guidelines, clinically-derived edits and federal regulations and Blue Cross policies.

- Blue Cross' editing system manages reimbursement policy, coding policy, medical policy, benefit rules and industry standard coding guidelines.
- It helps ensure accurate and consistent payments in accordance with coding, billing, reimbursement and clinical policies.
- It manages compliance with standard coding and billing practices between various types of services, such as medical, surgical, lab, DME and radiology.

We have a claims-editing tool available in iLinkBlue under the "Claims" menu option that will allow you to access our code-editing system logic. View our *iLinkBlue User Guide* for more information on researching code combinations in the claims-editing system tool. It is available on our Provider Page at www.bcbsla.com/providers >Resources >Manuals.

CODE EDITING: BILLING PRACTICES SUBJECT TO REDUCTION

Reductions in payment due to code editing are considered above allowable amounts and appear on the Payment Register/Remittance Advice in the above allowable amount column. These amounts are not collectable from the Blue Cross member.

Unbundling

Unbundling occurs when two or more CPT or HCPCS codes are used to describe a procedure performed when a single, more comprehensive code exists that accurately describes the entire procedure. The unbundled procedures are considered included in the proper comprehensive code as determined by Blue Cross and is included in the allowable charge of the comprehensive code. Blue Cross will provide benefits according to the proper comprehensive code.

Incidental Procedures

Incidental covered procedures, such as the removal of appendix at the time of other intra-abdominal surgery with no pathology, are not reimbursed separately. The incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the more extensive procedure. The allowable charge for the primary procedure includes coverage for the incidental procedure(s). If the primary procedure is not covered, any incidental procedure(s) will not be covered.

Mutually Exclusive Procedures

Mutually exclusive procedures are two or more procedures that usually are not performed at the same session on the same patient on the same date of service. Mutually exclusive procedures also may include different procedure codes and descriptions for the same type of procedures in which the physician should be submitting only one of the codes. One or more of the duplicative procedures is not reimbursable as it should be reimbursed only one time.

Pre and Post-op Billing

Certain codes will deny because these services should be included in the global practice. Currently global days for Blue Cross are 10 days for minor procedures and 45 days for major procedures.

Maximum Frequency

Blue Cross applies maximum frequency limitations to claims. The allowable will be adjusted to reflect the amount allowed for the updated units. The units denied will be reflected in the rejection reason as well as on the electronic 837 record.

Rebundles

Rebundles occur when two or more codes are billed instead of one more appropriate comprehensive code. Provider can refile the correct, comprehensive code.

Evaluation and Management

Evaluation and Management (E&M) rules apply to the E&M services included in the following codes and code ranges:

- 99202-99499
- 99024 (miscellaneous services)
- 92002-92004 & 92012-92014 (ophthalmology)

The separate billing of an E&M service will not be allowed when a substantial diagnostic or therapeutic procedure has been performed on the same date of service by the same provider.