Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Payment Policy POL-PP-105	
Subject: General Coding and Billing	
Effective Date: 7/01/2019	Committee Approval Obtained: 07/01/2019 Last Review: 07/01/2023 Next Review: 07/01/2024
The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.bluekc.com/ContactUs/PaymentPolicies**	
Provider Payment policies are written to provide an overview of coding and payment guidelines as they pertain to claims submitted to Blue KC. These guidelines are not intended to provide billing or coding advice but to serve as a reference for facilities and providers. **Covered services and payment** are based on the member's benefit plan and provider agreement. Providers and their office staff may use our online tools to verify effective dates and member copayments before providing services. Visit our providers page for information on member eligibility and benefits. Member liability may include, but is not limited to, co-payments, deductibles, and co-insurance. Members' costs depend on member benefits. Certain services require prior authorization or referral. **Blue KC reimburses** health care providers based on your contracted rates and member benefits. Claims are subject to payment edits, which Blue KC updates regularly.	
Policy	Blue KC reimburses contracted health care providers for covered, medically necessary services. Medical coding is the process of converting diagnosis, procedures and supply information provided by healthcare individuals into ICD-10, CPT and HCPCS codes for billing purposes. Billing is the process of electronically filing claims electronically to Blue KC using encrypted technology to secure patient information. **Blue KC reimburses:** ▪ Current Procedural Terminology (CPT) Level I codes o Five-digit numeric codes maintained by the American Medical Association (AMA). Used to describe medical, surgical, and diagnostic services, including radiology, anesthesiology, and evaluation and management services of physicians, hospitals, and other healthcare providers.

	▪ Healthcare Common Procedure Coding System (HCPCS) Level II codes o Alpha-numeric codes (one letter followed by four numbers) for medical services not included in Level I. For example, durable medical equipment, ambulance services, drugs, and supplies. ▪ HCPCS National "S" codes o Temporary codes for private payer use. ▪ Current Dental Terminology (CDT) codes o Dental codes maintained by the American Dental Association (ADA). ▪ International Classification of Diseases, 10th revision (ICD-10-CM) o ICD-10 codes are used to indicate diagnosis or condition and are required on all claims. ▪ Revenue codes o Four-digit numeric codes used by institutional providers. HCPCS or CPT codes may be required in addition to specific revenue codes, to describe the services rendered. ▪ Modifiers o CPT and HCPCS - Two-character alpha and numeric codes used to add additional information to coding. ▪ Add-on codes o When billed with a qualifying primary CPT or HCPCS code designated by the National Correct Coding Initiative Add On edit table Add-on codes may not be billed as the sole service provided. **Blue KC does not reimburse** the procedures or categories of codes outlined below. This list is not all inclusive. ▪ Category II CPT codes (XXXXF). This code set is a set of supplemental tracking codes that can be used for performance measurement and are intended to facilitate data collection. Using these codes is optional for correct coding and may not be used as a substitute for Category I codes. These codes are intended to facilitate data collection about quality of care. If billed, they will be denied provider liability. ▪ Codes identified as non-payable CMS indicator in the National Physician Fee Schedule Relative Value File

	will not be separately reimbursed by Blue KC. (Please refer to CMS guidelines for additional information.) ▪ PC/TC Indicator 5 codes. Blue KC will deny "Incident To" codes identified with a CMS PC/TC indicator 5 in the National Physician Fee Schedule Relative Value File when reported in a facility and billed by a physician. If billed 2 of 6 incorrectly, PC/TC indicators will be denied provider liability. (Please refer to CMS guidelines for additional information.) ▪ "T" codes o HCPCS codes exclusively for the use of state Medicaid agencies. Blue KC does not reimburse "T" codes except for a limited number of contracts and services. If billed incorrectly, it will deny provider liability. ▪ "M" codes o HCPCS codes used for measurement and reporting. ▪ Multianalyte Assays with algorithmic analysis not assigned a Category I CPT code. ▪ A HCPCS code when an equivalent or similar CPT code exists describing the same service or procedure, unless directed otherwise in a specific policy. ▪ C-codes when an equivalent CPT code exists. If an equivalent does not exist, a claim submitted with a C-code may be reimbursable. ▪ NOC (not otherwise classified) or unlisted codes without supporting documentation. ▪ Hospital mandated on-call service. **Claims edit** Blue KC uses claims editing software for automated claims coding verification. Claims are processed in compliance with general industry standards. The policies included in the claims editing software are incorporated as policies of Blue KC. The claims editing software: ▪ Uses a comprehensive set of rules. ▪ Provides consistent and objective claims review by reviewing both the CPT and HCPCS codes submitted and by detecting inaccuracies in coding including unbundling, up-coding, fragmentation, duplicate coding, invalid codes, and mutually exclusive code pairs.

	▪ Updated quarterly to incorporate the most recent medical practices, coding practices, annual changes to the AMA's CPT manual, and other industry standards such as CMS and Clinical Review. **Assistants** ▪ Individuals in training (e.g., students, trainees, interns, residents, fellows) are not considered an assistant and services are not reimbursable, unless otherwise communicated in writing by Blue KC. ▪ Unless otherwise prohibited by Blue KC administrative policies, procedures, coding requirements, guidelines, rules, or regulations, we reimburse no more than three assistants (to the extent consistent with the applicable law or regulation) who satisfy the following criteria: ▪ The assistant is salaried, employed, or reimbursed for services by that individual provider, professional corporation, or group practice. ▪ The assistant is licensed to perform such services, if applicable, and complies with all other registration, certification, accreditations and/or requirements applicable to the assistant's profession. ▪ The assistant performs the services under the direct, personal, and continuous supervision of a Blue KC participating individual provider ("assistant's supervising provider") who is licensed to perform the services rendered and is permitted under the assistant's practice guidelines and/or regulations to supervise the assistant, except to the extent permitted in writing by Blue KC. ▪ "Direct, personal, and continuous supervision" means that the assistant's supervising provider actively participates in the continuing management of the patient's treatment and is on the same premises and immediately available to give personal assistance and direction. Availability by telephone or electronic media does not constitute direct, personal, and continuous supervision, although the assistant's supervising provider need not be in the room where the assistant renders services. ▪ The assistant's supervising provider must provide documentation or attestation of the collaboration in the medical record by signing and dating the member's chart in accordance with our written guidelines.

The assistant performs services that are within the scope of the supervising provider's license and are customarily included in that supervising provider's bill, regardless of the patient's method of payment.

- Reimbursement for covered services by an assistant may differ from the provider fee schedule.

Payment for clinician services in a hospital teaching setting
Blue KC does not reimburse services performed by trainees alone. Blue KC will reimburse credentialed and contracted teaching clinicians for their oversight of services performed by trainees. The teaching clinician must cosign any notes documented in the medical records by trainees and the teaching clinician must also document at a minimum:

- The specific services he or she personally performed.
- The specific critical or key portions of services performed by trainees in which he or she was present.
- His or her participation in the management of the patient.
- The combined entries into the medical record by the teaching clinician and trainee constitute the documentation for the service and together must support the medical necessity of the service.
- Documentation by the trainee or the presence and participation of the teaching clinician is not sufficient to establish the presence and participation of the teaching clinician.
- The teaching provider must complete their documentation in the medical record before submitting claims to ensure notations by trainees are accurate and complete to support correct coding of services.

Locum Tenens
A locum tenens physician is a physician who works in place of the regular physician when that physician is absent, or when a hospital or practice is short-staffed. A locum tenens physician is credentialed following the same criteria as any network physician. Blue KC does not cover services provided by a locum tenens physician unless the physician is credentialed and contracted with Blue KC.

Specific billing guidelines

- Please note, the absence or presence of a procedure code or service does not imply or guarantee coverage or reimbursement.
- Blue KC will accept only standard diagnosis and procedure codes that comply with HIPAA (Health Insurance Portability and Accountability Act) transaction code set standards.
- The assistant eligible to participate with us must have a national provider identifier (NPI) and bill under that NPI (in 24J lower on the CMS-1500 form).

Codes	Descriptors	Notes
0001F-9007F	Category II CPT codes	Not reimbursed
0002M, 0004M, 0006M, 0007M,	Multianalyte assays with algorithmic analyses (MAAA) codes	Not reimbursed
00100-99607	Category I CPT code	
0019T-0542T	Category III CPT codes	Valid for applied behavior analysis (ABA), effective 10/1/16
99026	Hospital mandated on call service; in-hospital, each hour	Not reimbursed
90927	Hospital mandated on call service; out-of-hospital, each hour	Not reimbursed
M1000-M1071	Measurement codes	Not reimbursed, for reporting only
PC/TC Indicator 5 codes (MPFS)	Codes that describe services incident to a physician's service when provided by auxiliary personnel employed by the Physician in an inpatient or outpatient setting	PC/TC indicator 5 code not reimbursed to physicians in a facility
Status B codes (CMS National Physician Fee Schedule RVU file)	Covered service codes billed by a physician or other qualified health professional for which payment is always bundled into other non-specified services	Status "B" bundled code not reimbursed either when billed alone or with another service

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<tr><td></td><td>
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<tr><td>T1000 - T5999</td><td>HCPCS temporary national codes established by Medicaid</td><td>See statement above for reimbursement information</td></tr>
<tr><td>A0021- V5364</td><td>HCPCS level II codes</td><td></td></tr>
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When submitting claims for reimbursement, report all services with:

• Up-to-date industry-standard procedure and diagnosis codes.
• Modifiers that affect payment in the first modifier field, followed by informational modifiers. See Modifier Payment Policy for more information.</td></tr>
<tr><td>History</td><td>Effective date 7/1/2019
Approval date 7/1/2019</td></tr>
<tr><td>Review</td><td>7/1/2020 – annual review no changes
7/1/2021 – annual review, updated references and research material to AMA, ADA, and CMS guidelines.
7/1/2022-removed “There are exceptions to this rule for certain provider types” from Specific Billing guidelines, 3rd bullet. Removed assist at surgery.
7/1/2023 – Annual review, there were no updates or changes to this policy.</td></tr>
<tr><td>References and Research Materials</td><td>AMA
CMS Guidelines</td></tr>
<tr><td>Related Policies</td><td>N/A</td></tr>
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This document is for informational purposes only and is not an authorization, an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical Technology is constantly changing, and Blue KC reserves the right to review and update policies as needed.