PRICING AND ADJUDICATION PRINCIPLES

Origination: 06/2022
Last Review: 11/2024

Description

Blue Cross Blue Shield of North Carolina (Blue Cross NC) provides information to practitioners regarding claims pricing and adjudication processes to help them understand reimbursement for covered services provided to eligible Blue Cross NC members.

Since the number, setting, scope and type of service provided to members varies, it is impractical to document the process of adjudication of each claim submitted. Also, reimbursement is impacted by various statutes and regulatory requirements, professional contracts, and member benefits.

Blue Cross NC utilizes the guiding principles outlined below for claims processing and adjudication. These principles may help practitioners anticipate and understand the likely outcome of claims submissions.

Blue Cross NC claims reimbursement is determined by CMS, member benefits, provider contracts and fee schedules, and statutory and regulatory requirements.

The claims pricing and adjudication process includes Blue Cross NC primary claims processing systems, industry-standard claims adjudication software, individual review of claims and/or medical records by Blue Cross NC staff (where necessary), and external independent review (as needed).

Blue Cross NC uses several reference guidelines in developing its claims adjudication logic, including but not limited to the American Medical Association's Current Procedural Terminology (CPT®) manual, the CMS Correct Coding Initiative (CCI), and Medicare (CMS) guidelines. These reference guidelines were developed for varying populations and benefit structures, and are not uniformly consistent with each other. In consultation with Blue Cross NC provider advisory groups, Blue Cross NC adopts the adjudication logic that represents the most commonly encountered clinical scenarios; and is most appropriate for Blue Cross NC benefit plans, contracts, and marketing demographics.

This policy does not apply to contractual reimbursement methodologies outside fee-for-service, such as bundled payment for episodic care or care management, or quality-based reimbursement.

Principles

1. Blue Cross NC reimburses only for specific services or supplies rendered to specific members. General administrative/oversight services are not reimbursable under Blue Cross NC health benefit plans.
2. Blue Cross NC rationale for reimbursement is based on CMS guidelines, including manuals, NCDs, articles, MLNs, transmittals, regional carrier LCDs, articles and instructions.
3. Blue Cross NC will reimburse a given service or supply once. A given service or supply may be split (e.g., technical and professional components), but if a global fee is charged by one provider, an additional component fee will not be reimbursed.

4. Blue Cross NC will use industry-standard claims adjudication logic/software to process claims, with implementation oversight by a cross-functional corporate level team. Claims may be processed according to same group practice or same provider ID. Same group practice is defined as a physician and/or other qualified health care professional of the same group and same specialty with the same Federal Tax ID number.

5. Fee schedule pricing for the new services/products will be based on RVU's wherever possible, or other NC Medicare allowables/fees. Sources for RVU's will be Medicare, or other recognized source if Medicare does not assign RVU's for the specific code involved.

6. In general, Blue Cross NC does not allow a severity adjustment to fee allowances. For example, the use of Modifier 22 will not affect claims processing adjudication.

7. Blue Cross NC will base payment for new technology (pending assignment of RVU's as above) on the outcome of the treatment rather than the "technology" involved in the procedure.

8. Blue Cross NC will develop a pricing methodology for new or previously unpriced services whenever possible and apply the same methodology to all claims. The methodology will be communicated to all staff involved in making pricing determinations.

9. Blue Cross NC will utilize APC group pricing when applying rankings and percentages to outpatient facility services.

10. Because reimbursement depends on the specific product as a result of different benefit designs, claims adjudication methodology, medical policy, and provider contracts, creation or presence of a CPT code or HCPCS code in the respective manual does not guarantee reimbursement. Likewise, a fee in the provider fee schedule for a particular code does not guarantee reimbursement.

11. Unless the CPT book or other authoritative reference refers to a number of units of service or amount of time per service, Blue Cross NC assumes "one unit of service" basis for all CPT codes.

12. If an edit or class of edits does not perform as expected, the edit or class of edits will be reviewed to determine if it is reasonable, appropriate, and complies with Blue Cross NC contracts, State law, or standard of practice in North Carolina, and appropriate action will be taken.

13. In the event of any overpayment, duplicate payment, or other payment by us in excess of the member's benefits payable according to the member's benefit plan ("Overpayment") and all Blue Cross NC policies, you shall promptly remit the overpayment to Blue Cross NC. In addition to other remedies, if within forty-five (45) days of a request for refund by us, the requested refund has not been made we may recover the overpayment amount by offset of future amounts payable to you. Neither Blue Cross NC nor you may initiate recovery of overpayments or underpayments, respectively, any later than twenty-four (24) months after the date of the original claim payment with the following exceptions:

    a. Fraud, misrepresentation and other intentional misconduct
    b. Contractual requirements of self-funded groups
    c. Contractual requirements of certain Provider contracts
    d. Statutory or regulatory compliance
    e. Unsolicited or self-reported refunds.

14. Blue Cross NC follows the instruction and guidance of code issuers, including but not limited to CPT®, HCPCS, CMS-1500, UB-04, and ICD-10.

15. Blue Cross NC will review claims for duplicates based on varying elements, including but not limited to, member ID, provider ID, tax ID, provider specialty, CPT/HCPCS code, modifiers, diagnosis code, units, place of service, charge amount. Duplicate claims are not eligible for reimbursement.

16. Blue Cross NC will use its best efforts to apply editing logic that is consistent with industry, AMA, HCPCS (Level 1 and Level2) or CMS standards in effect at the time of the date of service. All Provider services must be billed, consistent with Original Medicare billing guidelines.

17. Blue Cross NC does not reimburse for services related to denied or non-covered procedures or services.

18. When a claim is identified for post-payment review, any requested medical records must be received within sixty (60) calendar days of the initial request. If the requested documentation is not received, the claim will be subject to a technical denial, and funds may be recouped or adjusted against future payments. For claims receiving a post-payment technical denial for lack of records, providers should follow instructions listed in the denial notice when submitting a reconsideration request.

Guidelines

Blue Cross NC may request medical records for determination of medical necessity or coding accuracy. When medical records are requested, letters of support and/or explanation are often useful but are not sufficient documentation unless all specific information needed to make a determination is included.

References

American Medical Association, Current Procedural Terminology (CPT®)

Centers for Disease Control and Prevention, International Classification of Diseases, 10th Revision. https://www.cdc.gov/nchs/icd/icd10.htm

Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual. Publication 100-04. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912

Healthcare Common Procedure Coding System

History

6/1/2022	New policy developed. Medical Director approved. **Notification on 3/31/2022 for effective date 6/1/2022**. (eel)
12/31/2022	Routine Policy Review. Minor revisions only. (cjw)
11/12/2023	Added bullet 16 for overlapping or duplicative services. Medical Director approved. **Notification on 9/12/2023 for effective date 11/12/2023**. (tlc)
1/1/2024	Bullets added for CMS rationale for reimbursement and reimbursement for denied or non-covered codes. Medical Director Approved. **Notification on 11/1/2023 for effective date 1/1/2024.** (ss)

2/01/2025	Post-pay medical record request technical denial language added. Added coding accuracy in guidelines section. RPOC approved. **Notification on 12/01/2024 for effective date 2/01/2025.** (ss)

Application

These reimbursement requirements apply to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services.

This policy relates only to the services or supplies described herein. Please refer to the Member's Evidence of Coverage (EOC) for availability of benefits. Member's benefits may vary according to benefit design; therefore, member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.