PRICING AND ADJUDICATION PRINCIPLES

Origination: 2/2004
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 employer group contracts, member benefits, provider contracts and fee schedules, and statutory and regulatory requirements.

The claims pricing and adjudication process includes commercial 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 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.

3. 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 provider or same group practice. 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. Blue Cross NC will consistently rank codes on facility claims according to their allowed amounts.

9. 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.

10. 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.

11. 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.

12. 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.

* The twenty-four (24) months time limit does not apply to Federal Employee Health Benefit Plan ("FEP") claims.

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

14. 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.

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

16. Blue Cross NC will not reimburse for overlapping or duplicative services.

17. 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®)

Healthcare Common Procedure Coding System

Centers for Disease Control and Prevention, International Classification of Diseases, 10th Revision. ICD - ICD-10 - International Classification of Diseases, Tenth Revision (cdc.gov)

Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual. 100-04 | CMS

History

2/04	Original policy issued.
11/04	Corrected the title to match the file name.
4/07/05	Medical Policy Advisory Group reviewed policy on 03/10/2005. No changes to the policy required.
5/08/06	Medical Policy Advisory Group review 3/24/06. No change to policy criteria. Policy number added to the Key Words Section.
3/26/07	Under the description section, changed the wording from “adjustment logic" to "adjudication logic" in paragraph six. Medical Policy reviewed by Senior Medical Director of Network Support.
12/03/07	Item number 11 under the section titled "Principles," revised the following statements: “Commencing January 1, 2004, BCBSNC will limit payment recoveries to a two-year timeframe from the date the claim was processed for fully insured and self funded business such that no demand for refund will occur for services processed prior to January 1, 2002 with the following exceptions:" to "Commencing December 1, 2007,

	BCBSNC will limit payment recoveries to an eighteen month timeframe from the date the claim was processed for fully insured and self funded business such that no demand for refund will occur for services processed prior to June 1, 2006, with the following exceptions:".
05/05/08	Policy reviewed 4/16/2008 by Vice President and Senior Medical Director of Provider Partnerships, Medical and Reimbursement Policy. Number 11 under the section titled "Principles" revised the following statements from "Commencing December 1, 2007, BCBSNC will limit payment recoveries to an eighteen month timeframe from the date the claim was processed for fully insured and self funded business such that no demand for refund will occur for services processed prior to June 1, 2006, with the following exceptions:" to "Commencing December 1, 2007, BCBSNC will limit initiation of overpayment recoveries to an eighteen month timeframe from the date of the original claim payment for fully insured and self-funded business such that no demand for refund will occur for services processed prior to June 1, 2006, with the following exceptions. Revised 11.a. from "Fraud, misrepresentation" to "Fraud, misrepresentation and other intentional misconduct,". Inserted 11.C. Contractual requirements of certain Provider contracts, and moved "Statutory or regulatory compliance, to 11.D. Moved "Governmental program limitations" to 11.E. Added 11. F. "Unsolicited or self-reported refunds."
6/22/10	Policy Number(s) removed (amw)
10/15/13	Policy was reviewed and the following changes were made: 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. Item 5 in the Principles section added clarification: "For example, the use of modifier -22 will not affect claims processing adjudication." Item 11 in the Principles section-deleted "governmental program limitations." The last statement following Item 11 was revised to read: This policy applies to BCBSNC commercial business and Inter-Plan Programs. (adn)
5/13/14	Policy category changed from "Corporate Medical Policy" to "Corporate Reimbursement Policy". No changes to policy content. (adn)
11/24/15	Routine review. No change to current policy. (adn)
12/30/16	Routine review. No change to current policy. (an)
12/29/17	Item 11 in the Principles section was revised to read: 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: Fraud, misrepresentations and other intentional misconduct; Contractual requirements of self-funded groups; Contractual requirements of certain Provider contracts; Statutory or regulatory compliance; Unsolicited or self-reported refunds. *Thirty-six (36) months for Federal Employee Health Benefit Plan ("FEP") claims. Notification given 12/29/17 for policy effective date 3/9/2018. (an)
6/8/18	The footnote under Item 11 in the Principles section was revised to read: The twenty-four (24) months time limit does not apply to Federal Employee Health Benefit Plan ("FEP") claims. (an)
12/14/18	Routine annual review. No change to current policy. (an)
1/14/20	Routine policy review. Senior Medical Director approved 12/2019. No changes to policy statement. (an)

12/31/20	Routine policy review. Medical Director approved 12/2020. No changes to policy statement. (eel)
4/20/21	Policy format update. No changes to policy statement. (eel)
12/30/21	Routine policy review. Grammatical corrections. Medical Director approved. (eel)
6/1/22	Policy renamed from "**Pricing and Adjudication Principles for Professional Providers**" to "**Pricing and Adjudication Principles**". Policy language updated throughout. Principle 3 updated to include "Claims may be processed according to same provider or same group practice. 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." Principle 11 removed language "after the implementation of a software update". Principle 13 and 14 added. Medical Director approved. **Notification on 3/31/2022 for effective date 6/1/2022**. (eel)
8/23/2022	Content extracted from provider manual and medical policy to clarify related services. Principle 15 added: Blue Cross NC does not reimburse for services related to denied or non-covered procedures or services. Medical Director approved. (ckb)
12/31/2022	Routine policy review. Minor revisions only. (ckb)
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)
2/01/2025	Postpay medical record request technical denial language added. RPOC approved. Added coding accuracy in guidelines section. **Notification on 12/01/2024 for effective date 2/01/2025.** (ss)

Application

These reimbursement requirements apply to all commercial, Administrative Services Only (ASO), and Blue Card Inter-Plan Program Host members (other Plans members who seek care from the NC service area). This policy does not apply to Blue Cross NC members who seek care in other states. Blue Cross NC will require its outside vendors to adhere to Blue Cross NC's payment recovery policies and procedures.

This policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet 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.