Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Clinical editing billing tips

For Blue Cross commercial, Medicare Plus Blue℠ Blue Care Network commercial and BCN Advantage℠

June 5, 2024

In this document

Blue Cross Blue Shield of Michigan and Blue Care Network use nationally recognized clinical editing programs that automatically compare procedure codes billed on claims against nationally accepted coding and billing standards to check for clinical appropriateness and data accuracy. We publish these tips to help our providers avoid claim delays and denials.

The tips in this document apply to Blue Cross commercial, BCN commercial or Medicare Plus Blue health plans as noted for each item.

CLIA-waived tests for Medicare Plus Blue claims

For Medicare Plus Blue

On July 1, 2024, we'll begin applying clinical editing denials when Clinical Laboratory Improvement Amendments-waived laboratory tests performed in an office, place of service 11, are submitted without appending the QW modifier in the first-position modifier field. Correct coding for CLIA-waived tests requires the QW modifier if the service is not performed in a facility or laboratory. This requirement was previously communicated in the Sept. 2017 issue of *The Record*: Reminder: CLIA numbers must be submitted for most lab tests.

Critical care in the ER when patient is discharged to home in the same encounter

For Medicare Plus Blue and BCN commercial

Through medical record audit reviews, Blue Cross and BCN have identified that claims billed for critical care services are often miscoded when the patient is discharged to home. If the patient is discharged from the emergency room to home, and the patient is not critically ill as defined by the American Medical Association and the Centers for Medicare & Medicaid Services guidelines, billing an ER evaluation and management, or E/M, code may be more appropriate.

On Sept. 9, 2024, Blue Cross' Medicare Plus Blue and BCN commercial plans will begin to deny critical care services submitted on an ER outpatient claim when the patient is discharged to home (discharge status of 01) following the encounter.

Providers are encouraged to review claims for proper billing and coding prior to submission. Providers may rebill with a lower CPT* code, when appropriate. If in disagreement with any denials received, appeals can be submitted following the clinical editing appeals process.

Impacted codes:

- Procedure codes: *99291, *99292
- Revenue codes: 450-459
- Discharge status: 01

ICD-10-CM 7th character and therapy codes clinical editing update for Medicare Advantage claims

For Medicare Plus Blue and BCN Advantage

Per ICD-10-CM coding, when billing an ICD-10 that requires a 7th character, the provider must append the correct alpha numeric character to identify if the member is receiving active treatment (A), subsequent treatment (D), or sequela (S).

For a member to receive physical, occupational or speech therapy, CMS requires that a physician or non-physician practitioner must clinically certify the treatment plan or plan of care prior to beginning treatment. The ICD-10 guidelines for the 7th character state that active treatment occurs when the provider sees the patient and develops a plan of care. When the patient is following the plan, that is a subsequent visit. Since a plan of care is required prior to starting therapy treatment, "D" (subsequent) must be used for all therapy billed with an ICD-10 requiring a 7th character.

Effective Sept. 9, 2024, this coding update will deny physical, occupational or speech therapy procedure codes when an ICD-10 diagnosis code in any position is billed with the 7th character "A" (active) on a claim line for professional and outpatient claims. If a modality procedure code is submitted on the same date of service, by the same provider, with the same diagnosis code as the therapy procedure code, the modality claim line will also be denied.

Outpatient services during an inpatient stay are not separately reimbursable

Blue Cross commercial, BCN commercial, Medicare Plus Blue and BCN Advantage

Blue Cross and BCN don't separately pay for hospital services during a member's inpatient facility stay. Unless otherwise specified in the members' plan documents, services provided during a member's inpatient facility admission should be billed by the inpatient facility. This requirement was previously communicated in the May 2023 issue of *The Record*: Reminder: Outpatient services provided during inpatient admission should be reported with inpatient claim.

When a member is inpatient at a hospital, and the member must leave the facility to receive medically necessary diagnostic or therapeutic services that are not available at the inpatient facility, the inpatient facility is responsible for the costs of the services not provided at their facility. Services that are obtained from another hospital or freestanding facility, usually because the admitting hospital does not have the necessary equipment or skilled personnel available to provide the service, are not separately reimbursable by Blue Cross or BCN.

Effective Oct. 1, 2024, this policy will be followed whether the outpatient facility provider has the same or different tax identification number as the inpatient provider. This policy applies to Blue Cross commercial, BCN commercial and our Medicare Advantage plans, Medicare Plus Blue and BCN Advantage. If the outpatient facility provider does not bill according to these guidelines, services will be denied.

Procedure not carried out reminder

For Blue Cross commercial

According to ICD-10-CM coding manual guidelines, certain "Z53" diagnosis codes (Persons encountering health services for specific procedures and treatment, not carried out) indicate the procedure was not carried out. When claims are billed with a "procedure not carried out" diagnosis and it is the only diagnosis billed, claims may be denied.

Prostate specimen re-bundle

For Blue Cross commercial
Blue Cross will be updating its payment policy for prostate needle biopsy specimen starting Sept. 9, 2024.

In alignment with the Centers for Medicare & Medicaid Services, this policy will require that surgical pathology for prostate needle biopsy specimens (including gross and microscopic examination) be reported with HCPCS code G0416, instead of *88305 when billed on the same date of service as a prostate biopsy. G0416 is considered the more appropriate code as it is specific for prostate needle biopsy only.

Depending on the quantity of units billed, claims that are submitted with *88305 may be edited and bundled under G0416.

- **G0416** — Surgical pathology, gross and microscopic examinations, for prostate needle biopsy, any method
- ***88305** — Level IV-Surgical pathology, gross and microscopic examination

Robotic/computer assistance and 3D imaging

For Blue Cross commercial
Blue Cross is updating its payment policy to not allow separate reimbursement for Robotic/computer assistance and 3D imaging.

Robotic assisted surgery is defined as the performance of operative procedures with the assistance of robotic technology. It is a method of performing the procedure, not a separate service. It is an integral part of the primary surgical procedure.

Three-dimensional images, referred to as 3D reconstruction or rendering, are applicable to computed tomography (CT), magnetic resonance imaging (MRI), ultrasound, or other tomographic modalities. It is a technology and technique that represents an aid to the physician via computer generated real-time study interpretation where decision support is considered an inherent component of the imaging procedure. Therefore, effective Sept. 9, 2024, separate visual enhancements reported with CPT codes *76376 and *76377 are not eligible for separate reimbursement.

***S2900** — Surgical techniques requiring use of robotic surgical system (List separately in addition to code for primary procedure)

***0054T** — Surgical techniques requiring use of robotic surgical system (List separately in addition to code for primary procedure)

***0055T** — Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)

***20985** — Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)

***76737** — 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation

***76377** — 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation

Sexually transmitted infection testing to be bundled

For Blue Cross commercial

In support of correct coding and payment accuracy, Blue Cross is updating its payment policy for sexually transmitted infection, or STI, testing starting Sept. 9, 2024.

When two or more single test codes are billed separately for the same member, health care provider and same date of service, we'll reimburse these services based on the rate for a single more comprehensive multiple organism code (CPT *87801 — Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique.)

The following are examples of single codes that would be bundled into *87801 if two or more are billed. This isn't an all-inclusive list:

- ***87491** — Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique
- ***87591** — Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique.
- ***87661** — Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, amplified probe technique

More information about clinical editing

Clinical editing resources

Learn more about clinical editing in our provider manuals. Here's how to find them:

1. Log in to our provider portal (availity.com**).
2. Click Payer Spaces on the menu bar and then click the BCBSM and BCN logo.
3. Click the Resources tab.
4. Click Provider Manuals.

Here's where to look in each manual:

- Blue Cross Commercial Provider Manual – Look in the Appeals and Problem Resolution chapter.
- BCN Provider Manual – Look in the Claims chapter, following the instructions listed above.
- Medicare Plus Blue Provider Manual – Look for the clinical editing section following the instructions listed above.

There's also a section of clinical editing reference documents available within our provider portal. Here's how to find it:

1. Follow the first three steps above.
2. Click *Secure Provider Resources (Blue Cross and BCN)*.
3. Click the dropdown next to Billing and Claims in the top menu.
4. Click on *Codes and Criteria* and scroll down to Clinical Editing.

Clinical editing appeals

For instructions on submitting a clinical editing appeal, refer to Appealing a clinical editing denial.

Questions about the clinical editing appeal process can be directed to Provider Inquiry. Here's how to find the Provider Inquiry phone number:

1. Go to bcbsm.com/providers.
2. Click *Help* and then click *Contact us*.

3. In the “select a plan type” field, click *Blue Cross Blue Shield of Michigan or Blue Care Network*.
4. In the “select a topic” field, click *Provider inquiry*.

*CPT Copyright 202r3 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.

**While Blue Cross Blue Shield of Michigan and Blue Care Network recommend this website and we’re responsible for its Blue Cross and BCN-specific content, we don’t own or control this website.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

None of the information included herein is intended to be legal advice and, as such, it remains the provider’s responsibility to comply with all applicable state and federal laws and regulations, including all coding and documentation requirements.