General Coding and Billing
Payment Policy

Policy

Blue Cross Blue Shield of Massachusetts (Blue Cross*) reimburses contracted health care providers for covered, medically necessary services.

General benefit information

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 eTools page for information on member eligibility and benefits. Member liability may include, but is not limited to: copayments, deductibles, and co-insurance. Members’ costs depend on member benefits.

Certain services require prior authorization or referral.

Payment information

Blue Cross reimburses health care providers based on your contracted rates and member benefits.

Claims are subject to payment edits, which Blue Cross updates regularly.

Blue Cross reimburses

- **Current Procedural Terminology (CPT) Level I codes.** 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.** 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.** Temporary codes for private payer use.
- **Current Dental Terminology (CDT) codes.** Dental codes maintained by the American Dental Association (ADA).
- **International Classification of Diseases, 10th revision (ICD-10-CM) codes.** Used to indicate diagnosis or condition. ICD-10 codes are required on all claims.
- **Revenue codes.** 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 (CPT and HCPCS).** Two-character alpha and numeric codes used to add additional information to coding.
- **Add-on codes** when billed with a qualifying primary CPT or HCPCS code. Add-on codes may not be billed as the sole service provided.
- **Services reported with a TC or 26 modifier** for procedures that allow these modifiers, as defined by the CMS National Physician Fee Schedule Relative Value File.

Blue Cross 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 deny with provider liability.
- **Bundled services/supplies (Status “B”).** Codes identified with a CMS indicator of “B” (bundled code) in the National Physician Fee Schedule Relative Value File will not be separately reimbursed by Blue Cross. Payments for these procedures are always bundled into payment for other services and separate payment is never made. If billed, they will deny with provider liability. Please refer to CMS guidelines for additional information.
- **Status Indicator “N” codes.** Codes identified with a CMS Outpatient Prospective Payment System (OPPS) status indicator of “N” will not be separately reimbursed to facilities by Blue Cross. Payments for these procedures are always bundled into payment for other services and separate payment is never made. If billed, they will deny with provider liability. Please refer to CMS guidelines Addendum B for additional information.
- **PC/TC indicator 5 codes.** Blue Cross 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
incorrectly, PC/TC indicators will deny with provider liability. Please refer to CMS guidelines for additional information.

- **“T” codes.** HCPCS codes exclusively for the use of state Medicaid agencies. Blue Cross does not reimburse “T” codes except for a limited number of contracts and services. If billed incorrectly, it will deny with provider liability.
- **“M” 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.
  - Blue Cross does not reimburse **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.
- **TOB Zero claims:** Claims submitted with a frequency code of ‘0’ (zero), which represents submission for informational purposes only.

**General reimbursement information**

**Claims editing**
Blue Cross uses claims editing software
- For automated claims coding verification
- To ensure that Blue Cross is processing claims in compliance with general industry standards.

The policies included in the claims editing software are incorporated as policies of Blue Cross.

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, incorrect procedure-to-modifier edits, add-on code edits, and mutually exclusive code pairs.
- Is updated quarterly to incorporate the most recent medical practices, coding practices, annual changes to the AMA’s CPT manual, and other industry standards.

Blue Cross offers a reference tool to allow providers to gain a better understanding of code auditing rules including incidental procedures, mutually exclusive procedures, bundling and unbundling procedures, and codes in conflict with age or gender. Please see Provider Central (bluecrossma.com/provider) for additional information.

**Assistants**
- Individuals in training (examples: students, trainees, interns, residents, and fellows) are not considered assistants and services are not reimbursable, unless otherwise communicated in writing by Blue Cross.
- Unless otherwise prohibited by Blue Cross administrative policies, procedures, coding requirements, guidelines, rules or regulations, Blue Cross reimburses 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 under Massachusetts law to perform such services, if applicable, and comply with all other registration, certification, accreditations, and requirements applicable to the assistant’s profession.
  - The assistant performs the services under the direct, personal, and continuous supervision of a Blue Cross-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 regulations to supervise the assistant, except to the extent permitted in writing by Blue Cross.
  - “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.
Individuals are considered assistants unless Blue Cross communicates otherwise.
Assistants are not provider types eligible to participate with Blue Cross.
The assistant eligible to participate with us must have a national provider identifier (NPI) and bill under that NPI. There are exceptions to this rule for certain provider types.
Reimbursement for covered services by an assistant may differ from the provider fee schedule.

Payment for clinician services in a hospital teaching setting only
Blue Cross does not reimburse services performed by trainees (students, trainees, interns, residents, fellows, etc.) alone. Blue Cross will reimburse credentialed and contracted teaching clinicians for their oversight of services performed by trainees in a teaching hospital setting. The teaching clinician must co-sign 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 furnished.
- The specific critical or key portions of services furnished 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.
- The teaching provider must complete their documentation in the medical record within seven days of the date of service and before submitting claims to ensure notations by trainees are accurate and complete to support correct coding of services.

Assist at surgery
- Blue Cross only reimburse contracted physicians, physician assistants-specialty care (PA-SC), nurse practitioners-specialty care (NP-SC) and certified nurse midwives (CNM) for assist-at-surgery 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 Cross does not cover services provided by a locum tenens physician unless the physician is credentialed and contracted with Blue Cross.

Modifier 25: Significant, separately identifiable evaluation and management (E/M) service
- Modifier 25 indicates a significant, separately identifiable E/M service by the same provider or other qualified health care professional on the same day of the procedure or other service. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.
- The submission of modifier 25 appended to a procedure code indicates that documentation is available in the patient’s records that will support the distinct, significant, separately identifiable nature of the E/M service submitted with modifier 25, and that these records will be provided in a timely manner for review when requested.
- All surgical procedures and some non-surgical procedural services include a certain degree of provider involvement or supervision, pre-service work, and post-service work which is integral to that service. For those procedures and services, a separate E/M service is not normally reimbursed.
- By assigning a global days indicator of “000” or “010,” CMS is indicating that the RVU for the procedure includes reimbursement for the assessment of the problem, determining that the procedure is necessary, evaluating whether the procedure is appropriate and the patient is a good candidate, discussing the risks and benefits, and obtaining informed consent, as well as performing the procedure. To support reporting a separate E/M with modifier 25, the evaluation must extend beyond what will be treated by the procedure.

Example of proper use of modifier 25
An established patient is seen in the office for a follow-up of their diabetes. While there, the patient asks the provider to address a new issue of left hip pain. The physician:
- Performed a problem-focused history and exam of the patient’s hypertension and diabetes, and changed the patient’s medications.
- Evaluated the hip and performed an injection/arthrocentesis.
Bill 99212-25 and 20610. The evaluation of the hip problem is included in CPT 20610. The patient was seen for a problem other than the hip, necessitating an E/M service.

Example of improper use of modifier 25

A patient sees the doctor with a complaint of multiple skin lesions in the neck and axilla area which are causing discomfort from itching and bleeding.

- The physician recommends removal of the lesions. 20 lesions are removed.
- Bill 11200 only. No E/M with modifier 25 is reported. The use of modifier 25 is not appropriate because the E/M service did not go above and beyond the usual preoperative service. Also, since CPT 11200 has a global period of 010 days, the decision for surgery E/M services on the same date of service as the minor surgical procedure are not eligible to be reported with modifier 57 either, but are included in the payment for the surgical procedure.

Modifiers 59, {XEPSU}: distinct and independent procedure or service

- Under certain circumstances, the provider may need to show that a procedure or service was distinct or independent from other non-E/M services performed on the same day. CPT modifier 59 is used to identify procedures and services, other than E/M services, that are not normally reported together but are appropriate under the circumstances.
- Documentation must support a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same provider.
- The primary purpose of CPT modifier 59 is to show that two or more procedures are performed at different anatomic sites or during different patient encounters. It should be used only if no other modifier more appropriately describes the relationship of the procedure codes.
- Effective August 1, 2019 modifier 59 will no longer automatically override the denial and allow for separate reimbursement on selective code to code edits or edits related to CPT designated “separate procedures.” Reimbursement may be considered after submission of office or procedure notes for review. To access the Modifier 59 Code Pairs click here: Modifier 59 Code Pairs.
- The Centers for Medicare & Medicaid Services (CMS) established four new HCPCS modifiers (XE, XS, XP, and XU) to provide greater reporting specificity in situations where modifier 59 was previously reported:

<table>
<thead>
<tr>
<th>Modifiers</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>XE</td>
<td>Separate encounter, a service that is distinct because it occurred during a separate encounter. Use this modifier only to describe separate encounters on the same date of service.</td>
</tr>
<tr>
<td>XP</td>
<td>Separate practitioner, a service that is distinct because it was performed by a different practitioner.</td>
</tr>
<tr>
<td>XS</td>
<td>Separate structure, a service that is distinct because it was performed on a separate organ or structure.</td>
</tr>
<tr>
<td>XU</td>
<td>Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.</td>
</tr>
</tbody>
</table>

- Do not report modifier 59 when a more specific X modifier is available.
- Because the X{EPSU} modifiers are more selective versions of the 59 modifier, it is incorrect to include both modifiers on the same line. Do not report the 59 modifier and the X{EPSU} modifier on the same line.
- Blue Cross will not stop recognizing the 59 modifier, however, note that CPT instructions state that the 59 modifier should not be used when a more descriptive modifier is available.

Examples of proper use of modifiers 59, X{EPSU}

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Scenario</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| 59       | Patient is having both:  
- Paring or cutting of benign hyperkeratotic lesion (example: corn or callus); single lesion (11055)  
- Debridement of nails by any method; one to five (11720) | • These are mutually exclusive procedures for CCI purposes.  
• CPT modifier 59 is only appropriate in this situation if these procedures are performed for lesions that are anatomically separate from one another or if procedures are performed at separate patient encounters.  
• Do not submit CPT codes 11055 through 11057 for removal of hyperkeratotic skin adjacent to nails needing debridement. |
### Modifier | Scenario | Rationale
--- | --- | ---
XE | Patient has an 8 a.m. surgery for one distinct procedure, and a 4 p.m. surgery for a second distinct procedure (separate surgical operative sessions on the same date of service). | Use XE on the second (4 p.m.) procedure because it is a separate encounter.

**XP**
- A patient saw her OB-GYN and oncologist on the same day (she is seen by two physicians in the practice on the same day).
- Use XP on the second encounter because it involves:
  - Separate practitioners.
  - Same date of service.
  - May or may not be the same encounter.
  - May or may not be different specialties.

**XS**
- Patient receives an injection in the right hip (20605) and an injection into tendon sheath, right ankle (20550-XS).
- Use XS on 20550 because:
  - Same encounter.
  - Different anatomical site.

**XU**
- A diagnostic procedure is performed. Based on the findings, a therapeutic or surgical procedure is required on the same day. For example, diagnostic cardiac catheterization is followed by a medically necessary cardiac procedure.
- Use XU because:
  - Same encounter.
  - Same practitioner.
  - Same anatomical site, structure, or organ.

### Examples of improper use of modifier 59, X {EPSU}
- When another established, more descriptive modifier is available and more appropriate.
- When used with an E/M service.
- To report a separate and distinct E/M service with a non-E/M service performed on the same date (use modifier 25, if appropriate).
- When a valid modifier exists to identify the services.
- When documentation does not support the separate and distinct status.
- When used to show multiple administration of injections of the same drug.

### Clinical editing update
Effective July 1, 2019, CMS will allow modifier 59 and X-EPSU subsets on column one (eligible for payment) codes and column two (denied) codes to bypass the edit.
- In Q4 2019, Blue Cross will adopt this CMS rule **only** for facility Medicare Advantage claims. Blue Cross will automatically reprocess eligible claims once the system is updated.
- Blue Cross will **NOT** adopt this change for commercial professional and facility or Medicare Advantage professional claims.

### Billing information

**Specific billing guidelines**
- Blue Cross 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 1500 form). There are exceptions to this rule for certain provider types.
  - The list of codes below is included for informational purposes only. This may not be a complete list of all the codes related to this service. Whether or not a code is listed here does not guarantee coverage or reimbursement.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0001F-9007F</td>
<td>Category II CPT codes</td>
<td>Not reimbursed.</td>
</tr>
<tr>
<td>0002M-0004M, 0006M, 0007M,</td>
<td>Multianalyte assays with algorithmic analyses (MAAA) codes</td>
<td>Not reimbursed. See Medical Policy.</td>
</tr>
<tr>
<td>00100-99607</td>
<td>Category I CPT codes</td>
<td></td>
</tr>
<tr>
<td>0019T-0542T</td>
<td>Category III CPT codes</td>
<td>Valid for applied behavior analysis (ABA), effective 10/1/16.</td>
</tr>
<tr>
<td>0362T, 0373T-0386T</td>
<td>Category III CPT codes</td>
<td></td>
</tr>
<tr>
<td>99026</td>
<td>Hospital mandated on call service; in-hospital, each hour</td>
<td>Not reimbursed.</td>
</tr>
<tr>
<td>Codes</td>
<td>Description</td>
<td>Notes</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>99027</td>
<td>Hospital mandated on call service; out-of-hospital, each hour</td>
<td>Not reimbursed</td>
</tr>
<tr>
<td>M1000- M1071</td>
<td>Measurement codes</td>
<td>Not reimbursed. For reporting only</td>
</tr>
<tr>
<td>PC/TC Indicator 5 codes (CMS National Physician Fee Schedule RVU file)</td>
<td>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</td>
<td>PC/TC indicator 5 code. Not reimbursed to physicians in a facility.</td>
</tr>
<tr>
<td>Status B codes (CMS National Physician Fee Schedule RVU file)</td>
<td>Covered service codes billed by a physician or other qualified health professional for which payment is always bundled into other non-specified services</td>
<td>Status “B” bundled code. Not reimbursed either when billed alone or with another service.</td>
</tr>
<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>
</tbody>
</table>

**Modifiers**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>59</td>
<td>Distinct procedural service</td>
<td>Effective July 1, 2019. CMS will allow modifier 59 and XEPSU subsets on column one (eligible for payment) codes and column two (denied) codes to bypass the edit.</td>
</tr>
<tr>
<td>XE</td>
<td><strong>Separate encounter.</strong> A service that is distinct because it occurred during a separate encounter</td>
<td>In Q4 2019, Blue Cross will adopt this CMS rule <strong>only</strong> for facility Medicare Advantage claims. Blue Cross will automatically reprocess eligible claims once the system is updated. Blue Cross will <strong>NOT</strong> adopt this change for commercial professional and facility or Medicare Advantage professional claims.</td>
</tr>
<tr>
<td>XP</td>
<td><strong>Separate practitioner.</strong> A service that is distinct because it was performed by a different practitioner.</td>
<td>Effective August 1, 2019 Modifier 59 will no longer automatically override the denial and allow for separate reimbursement on selective code to code edits or edits related to CPT designated “separate procedures.” See <strong>Modifier 59 Code Pairs.</strong> Reimbursement may be considered after submission of office or procedure notes for review.</td>
</tr>
<tr>
<td>XS</td>
<td><strong>Separate structure.</strong> A service that is distinct because it was performed on a separate organ/structure</td>
<td></td>
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<tr>
<td>XU</td>
<td><strong>Unusual non-overlapping service.</strong> The use of a service that is distinct because it does not overlap usual components of the main service</td>
<td></td>
</tr>
</tbody>
</table>

When submitting claims, report all services with:
- Up-to-date, industry-standard procedure and diagnosis codes, and
- Modifiers that affect payment in the first modifier field, followed by informational modifiers
<table>
<thead>
<tr>
<th>Date</th>
<th>Update Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/15/2014</td>
<td>Documentation of existing policy.</td>
</tr>
<tr>
<td>07/14/2015</td>
<td>Annual review; template update.</td>
</tr>
<tr>
<td>01/01/2016</td>
<td>Coding update of Category III CPT codes range; coding update of multianalyte assays with algorithmic analyses codes not reimbursed by Blue Cross.</td>
</tr>
<tr>
<td>03/31/2016</td>
<td>Annual review; template update; inclusion of documentation of existing policy on add-on codes, c-codes, and billing guidelines; updated date for ABA reimbursement of T codes.</td>
</tr>
<tr>
<td>09/30/2016</td>
<td>Inclusion of information on reimbursement guidelines for assistants which was previously stated in the assist at surgery payment policy.</td>
</tr>
<tr>
<td>01/01/2017</td>
<td>Annual review; template update; inclusion of updated CPT coding information; removal of deleted code 0010M; inclusion of reimbursement guidelines for moderate sedation.</td>
</tr>
<tr>
<td>06/01/2017</td>
<td>Updates to reimbursement guidelines for moderate sedation.</td>
</tr>
<tr>
<td>08/29/2017</td>
<td>Inclusion of information on claims editing software upgrade; removal of information on moderate sedation reimbursement. This information can be found in the anesthesia, gastroenterology, and surgery-professional payment policies.</td>
</tr>
<tr>
<td>01/01/2018</td>
<td>Annual review; coding update: expanded range of Category III codes; clarification that the claims editing software is updated quarterly effective December 29, 2017.</td>
</tr>
<tr>
<td>06/30/2018</td>
<td>Addition of billing guidelines for modifier 25 and 59 (ESPU), locum tenens, and payment for clinician services in a teaching setting.</td>
</tr>
<tr>
<td>12/31/2018</td>
<td>Annual coding update; removed deleted Category III codes for ABA, and replaced with valid range: 0362T, 0373T-0386T; expanded range of Category III codes to 0542T to include new codes; removed deleted codes 0001M and 0008M; added new “M” code category.</td>
</tr>
<tr>
<td>05/01/2019</td>
<td>Updated modifier 59 reimbursement information effective for August 1, 2019.</td>
</tr>
<tr>
<td>06/30/2019</td>
<td>Annual review; template update; edits for clarity on reimbursement information for assistants; inclusion of information on reimbursement guidelines for modifier 59 procedure-to-procedure edits; removal of December 29, 2017 notice of claims editing software upgrade.</td>
</tr>
<tr>
<td>08/01/2019</td>
<td>Per the HIPAA 837 Implementation Guide, inclusion of information on reimbursement policy for TOB Zero.</td>
</tr>
<tr>
<td>09/04/2019</td>
<td>Updated to reflect changes to outpatient reimbursement effective 2/1/2020 to deny OPPS SI=N codes</td>
</tr>
</tbody>
</table>

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 we reserve the right to review and update our policies periodically.

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Payment policies are intended to help providers obtain Blue Cross Blue Shield of Massachusetts’ payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy development takes into consideration a variety of factors, including: the terms of the participating provider’s contract(s); scope of benefits included in a given member’s benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.