



POLICY INFORMATION			
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Policy Status:	Active	Next Revision Date:	07/01/2026

NOTICE

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Blue KC reserves the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to: <https://providers.bluekc.com/ContactUs/PaymentPolicies>.

PROVIDER/ENTITY IMPACTED					
<input checked="" type="checkbox"/> PROFESSIONAL	<input checked="" type="checkbox"/> FACILITY	<input type="checkbox"/> DME	<input type="checkbox"/> AMBULATORY SURGERY	<input type="checkbox"/> LAB	<input checked="" type="checkbox"/> OTHER

LINES OF BUSINESS IMPACTED						
<input checked="" type="checkbox"/> COMMERCIAL	<input checked="" type="checkbox"/> BLUE MEDICARE ADVANTAGE	<input checked="" type="checkbox"/> ACA QHP¹	<input checked="" type="checkbox"/> SMALL GROUP ACA	<input checked="" type="checkbox"/> JAA²	<input checked="" type="checkbox"/> FEP³	<input type="checkbox"/> DENTAL

¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.



Description/Application

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 filing claims electronically to Blue KC using encrypted technology to secure patient information.

Policy

Blue KC 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)
 - ICD-10 codes are used to indicate a diagnosis or condition and 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 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
 - 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
 - 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 code 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.

Claim edits

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. Supervising 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).

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.

Billing Requirements for Outpatient Providers with Multiple Service Location

Report the service facility location for off-campus, outpatient, provider-based department of a hospital facilities in the 2310E loop of the 837 institutional claim transaction. Submitters also are required to report the service facility location for off-campus, outpatient, provider-based department of a hospital facilities. Paper submitters report the service facility address information in Form Locator (FL) "01" on the paper claim form.

When all the services rendered on the claim are from the billing provider address, providers are to report the billing provider



address only in the billing provider loop and not to report any service facility location.

When all the services rendered on the claim are from one campus of a multi-campus provider that report a billing provider address, providers are to report the campus address where the services were rendered in the service facility location if the service facility address is different from the billing provider address.

When all the services rendered on the claim are from the same off-campus, outpatient, provider-based department of a hospital facilities, providers are to report the off-campus, outpatient, provider-based department service facility addresses in the service facility provider loop.

When there are services rendered on the claim from multiple locations:

- If any services on the claim were rendered at the billing provider address, providers should report the billing provider address only in the billing provider loop 2010AA and do not report the service facility location in loop 2310E.
- If no services on the claim were rendered at the billing provider address, providers should report the service facility address from the first registered encounter of the "From" date on the claim.

For more information please see [SE18002 \(cms.gov\)](https://www.cms.gov).

Coding

Anesthesia codes 00100 - 01999

References and Resources

- Centers for Medicare and Medicaid Services
- American Medical Association CPT Manual
- Blue KC Provider Reference Guide

Related Documents

POL-PP-236 Blue KC CPT Evaluation and Management Services

Revision History

Version	Date	Summary of Revisions
001	07/01/2019	Initial version
002	07/01/2020	Annual review, there were no changes.
003	07/01/2021	Annual review, updated references, and research material to AMA. ADA and CMS
004	07/01/2022	Annual review removed "There are exceptions to this rule for certain provider types" from Specific Billing guidelines, 3rd bullet. Removed assist at surgery.
005	07/01/2023	Annual review, there were no updates or changes made to the policy



006	07/01/2024	Annual review, formatting changes
007	9/9/2024	Added information on Billing Requirements for Providers with Multiple Service Locations
008	07/01/2025	Annual review, there were no updates or changes made to the policy