POLICY INFORMATION			
Policy Number:	POL-PP-245	Original Effective Date:	6/1/2024
Version Number:	02	Revision Date:	6/1/2025
Policy Status:	Active	Next Revision Date:	6/1/2026

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					
☒ PROFESSIONAL	☒ FACILITY	☐ DME	☐ AMBULATORY SURGERY	☐ LAB	☐ OTHER

LINES OF BUSINESS IMPACTED						
☒ COMMERCIAL	☒ BLUE MEDICARE ADVANTAGE	☒ ACA QHP[1]	☒ SMALL GROUP ACA	☒ JAA[2]	☒ FEP[3]	☐ 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

The purpose of this policy is to provide an overview of the processes and procedures involved in our use of Lyric's (formerly Change Healthcare) clinically based claims editing solution, to help ensure that our code and claim editing rules are accurate and consistent with standard business practices and enables us to process claims efficiently and provide accurate reimbursement.

Policy

Editing - The practice by which one or more rule recommendations are made to Current Procedural Terminology (CPT®) codes or HCPCS Level II codes included in a claim that result in:

- Reimbursement is being made based on some, but not all, of the CPT/HCPCS codes included in the claim.
- Reimbursement being made based on different CPT/HCPCS codes than those included in the claim
- Reimbursement for one or more of the CPT/HCPCS codes included in the claim being decreased by application of multiple procedure logic.
- Reimbursement for one or more of the CPT/HCPCS codes being denied, or any combination of the above.
- Additional denials may be based on diagnosis, place of service, revenue code and other claim criteria.

History Editing - Lyric is able to identify previously submitted claims within our claim processing system's claim history that may be related to new claim submissions and that may result in adjustments to previously processed claims.

This history editing capability allows Blue KC to systematically adjudicate claims based on the guidelines of our reimbursement policies including, but not limited to, global surgery, multiple visits per day, pre/post-operative visits, new patient visits, frequency rules, incidental, mutually exclusive and rebundle edits, and maternity services.

Lyric allows Blue KC to utilize the software's clinical and rules-based logic to:

- Assess provider claims information including CPT/HCPCS procedure codes against a series of edit programs.
- Assess claims information, including CPT and Health Care Common Procedure Coding System (HCPCS) service codes to detect coding irregularities, conflicts, or errors.
- Recommend CPT/HCPCS procedure code combinations.
- Implement Blue KC's Medical and Payment Policies, National Correct Coding Initiative , and the Centers for Medicare and Medicaid Services Local and National Coverage Determinations,

- Put into practice the Centers for Medicare & Medicaid Services (CMS) coding and modifier guidelines and the National Correct Coding Initiative (NCCI) Incidental and Mutually Exclusive edits.

- The edits that are associated with a rule cause an audit action on a claim that directs how procedure codes and procedure code combinations will be adjudicated.

- The edits associated with the Lyric rules identify, for example and without limitation: age and gender specific procedures; incidental procedures; unbundled/rebundled procedures; mutually exclusive and/or redundant procedures; place, time and type of service requirements; incorrect coding of specific codes; service utilization requirements, such as the administration of anesthesia and/or use of an assistant surgeon; and services integrally related to a surgery (global surgery).

- Lyric incorporates coding edits and rules derived from a number of sources including, but not limited to, the CMS, NCCI, American Medical Association Complete Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), American Society of Anesthesiology (ASA), coding guidelines developed by national medical specialty societies, input from Lyric physician consultants, and Blue KC guidelines.

- Blue KC reserves the right to make customizations to its Lyric software tool. Blue KC will communicate and publish any such customizations prior to their implementation.

Documentation and Reporting

Providers are responsible for determining the most appropriate CPT and/or HCPCS codes, applicable modifiers, as appropriate, ICD-10 Diagnosis codes for the health care supplies or services they provide. The code(s) and modifier(s) must be valid for the dates of service reported, and describe the services provided. All claims submitted by a provider must be in accordance with the reporting guidelines and instructions contained in the AMA CPT Manual, "CPT® Assistant," HCPCS, and ICD-10 publications.

- The member's medical records must support the services described by the reported CPT/HCPCS code.

- Blue KC reserves the right to perform audits or investigations to confirm appropriate billing of services provided to our members.

- If a Lyric denial related to one of the rules listed below is received on remittance, it is recommended that the billing provider review the originally submitted claim information prior to initiating an appeal. If a coding error is detected, we ask that the appropriate corrected claim information be submitted.

Updates

Lyrics editing content will be updated on a quarterly basis. In addition to adding new CPT codes, HCPCS codes, and NCCI edits, Lyric also adds, or revises claim editing information based on their ongoing review of the entire knowledge base. This

ongoing process helps to ensure that the default clinical content used in Lyric is clinically appropriate and withstands the scrutiny of both payers and providers.

Lyric Rules

The following is a list of Lyric rules adopted by Blue KC. This is not a complete list and is subject to change or revision.

Age Rule: This claim editing logic identifies when an age specific procedure code is reported for a patient whose age falls outside the designated age range for procedure and/or diagnosis code is submitted. Age designations are assigned to select codes based on code descriptions or on publications and guidelines from sources such as professional specialty societies, CMS, and the AMA. When an age inconsistency is identified on a claim, the code(s) in question will be denied.

Gender-Specific Codes Rule:

This claim editing logic identifies when a gender-specific procedure and/or diagnosis code is submitted for a patient of a different sex. Gender designations are assigned to select codes based on code descriptions or on publications and guidelines from sources such as professional specialty societies, CMS, and the AMA. When gender inconsistency is identified on a claim, the code(s) in question will be denied.

Assistant Surgeon/Assistant at Surgery Rule: In accordance with Blue KC Assistants at Surgery payment policy, Lyric identifies procedure codes appended with an assistant surgeon modifier (80, 81, 82, AS) that do not typically require an assistant surgeon

Base Code Quantity Rule: The claim editing logic within this rule identifies claim lines where a primary service/procedure with a quantity greater than one is submitted, rather than the submission of that primary service procedure with appropriate add-on ("each additional") code(s). In such situations, the claim line item with the base code quantity greater than one will be denied.

This rule also identifies multiple occurrences of a base code reported on separate claim lines or on separate claims. Additional base code line item(s) or claims will be denied. Services performed in conjunction with the primary procedure should be submitted using the appropriate add-on codes.

Add-on code without Base Code Rule: The claim editing logic within this rule will identify add-on procedure codes (those codes denoted with a "+" that can be found in Appendix D in the CPT manual) that are submitted without the related primary service/procedure (base code). Add-on codes submitted without the base code will be denied. In addition, Add-on codes will be denied if the corresponding base code is denied

Bundled Services and Supplies Rule
This rule recommends the denial of claim lines where the submitted procedure is not recommended for reimbursement when submitted with one of the following: a more comprehensive procedure, a procedure that results in overlap of services, procedures that are medically impossible or improbable to be performed together on the same date of service. In certain cases, modifiers are taken into account and may potentially override the recommendation for denial.

Bilateral Billing Rule: This claim editing logic identifies any claim lines where the submitted procedure code was already billed or is subsequently billed with a modifier 50 for that same date of service. A service performed bilaterally should not be billed twice when reimbursement guidelines require the service to be submitted with a single procedure code appended

with a bilateral modifier. Lyric identifies the same code billed twice for the same date of service, where the first code has the bilateral modifier appended. This rule denies the second submission of the procedure code in question regardless of whether it is submitted with or without a bilateral modifier.

Diagnosis code validation: All diagnoses codes must be coded to the highest specificity as documented in the most current version of the International Classification of Diseases and be valid for the date of service being submitted. All submitted secondary diagnoses will also be validated. Claims or claim lines that include invalid, or incomplete diagnoses codes will be denied.

Modifier to Procedure code validation: Most modifiers apply to a specific group of procedure codes and may only be reported in conjunction with those specified procedure codes. Validation of appropriate procedure code/modifier combinations is based on CPT, CMS, and Lyric sourcing.

New Patient Evaluation and Management (E&M) Rule: This claim editing logic identifies any new-patient E&M procedure codes submitted for established patients. A new patient is defined as one who has not received any professional services from the rendering physician or another physician of the same specialty who belongs to the same group practice, within the previous three years. If our editing system identifies a new or established E&M code reported within the last three years, the new patient E&M code will be denied.

Procedure Unbundling Rule: Unbundling occurs when two or more procedure codes are used to describe a service when a single, more comprehensive procedure code exists that more accurately describes the complete service performed. Additional details regarding unbundling rules are listed below.

- **Incidental:** An incidental procedure is one that is performed at the same time as a more complex, primary procedure and is clinically integral to the successful outcome of that primary procedure. A separately billed procedure determined to be incidental to another procedure will not be considered for reimbursement.

Mutually Exclusive: Mutually Exclusive procedures consist of combinations of procedures that differ in technique or approach but lead to the same outcome and in some instances, the combination of procedures may be anatomically impossible. Procedures that represent

CMS Correct Coding Initiatives Rule: The claim editing logic within this rule denies claim lines for submitted procedures that are not recommended for reimbursement when submitted with another procedure according to CMS NCCI code pair guidelines. NCCI code pair edits may be reviewed online at https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-faq-library. The National Correct Coding Initiative table of edits does not include all combinations of correct coding or kinds of unbundling. You are required to code correctly, even if edits do not exist to prevent improper coding."

Outpatient Code Editor (OCE) CMS Correct Coding Initiative (CCI) Bundling Rule: This claim editing logic identifies claims containing hospital outpatient services/procedure code pairs found to be unbundled according to CMS I/OCE. Lyric will deny claim lines for which the submitted procedure is not recommended for reimbursement when submitted with another procedure as defined by a code pair found in the CMS OCE for one of the following reasons:

- Procedure is a mutually exclusive procedure that is not allowed by the CCI.

- Procedure is a component of a comprehensive procedure that is not allowed by the CCI.

Coding

N/A

Related Documents

POL-PP-226 National Correct Coding Initiative

References and Resources

Centers for Medicare and Medicaid Services
American Medical Association
Lyric

Revision History

Version	Date	Summary of Revisions
001	6/1/2024	Initial version
002	6/1/2025	Annual review, no changes were made