



Corporate Medical Policy

Pricing and Adjudication Principles for Professional Providers

File Name: pricing_and_adjudication_principles_for_professional_providers
Policy Number: ADM9104
Origination: 2/2004
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Next Review: 4/2009

Description

Blue Cross Blue Shield of North Carolina (BCBSNC) provides information to practitioners regarding its claims pricing and adjudication processes to help them understand their reimbursement for covered services provided to eligible BCBSNC 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.

BCBSNC utilizes the guiding principles listed below for claims processing and adjudication. These principles may help practitioners anticipate and understand the likely outcome of claims submissions.

BCBSNC 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 BCBSNC primary claims processing systems (Legacy and New Blue), industry-standard claims adjudication software (applies to New Blue only), individual review of claims and/or medical records by BCBSNC staff (where necessary), and external independent review (as needed).

BCBSNC uses several reference guidelines in developing its claims adjudication logic, including the American Medical Association's Current Procedural Terminology (CPT) manual, the CMS Correct Coding Initiative (CCI), Medicare (CMS) guidelines, and Claim Check. These reference guidelines were developed for varying populations and benefit structures, and are not uniformly consistent with each other. In consultation with BCBSNC provider advisory groups, BCBSNC adopts the adjudication logic that represents the most commonly encountered clinical scenarios; and is most appropriate for BCBSNC benefit plans, contracts, and marketing demographics.

Principles

1. BCBSNC reimburses only for specific services or supplies rendered to specific members. General administrative/oversight services are not reimbursable under BCBSNC health benefit plans.
2. BCBSNC 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. BCBSNC will use industry-standard claims adjudication logic/software to process claims within New Blue, with implementation oversight by a cross-functional corporate level team.
4. Fee schedule pricing for the new services/products will be based on RVU's wherever possible, or other

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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, BCBSNC does not allow a severity adjustment to fee allowances.
6. BCBSNC 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. BCBSNC 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. 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 require reimbursement. Likewise, a fee in the provider fee schedule for a particular code does not require reimbursement.
9. Unless the CPT book or other authoritative reference refers to a number of units of service or amount of time per service, BCBSNC assumes "one unit of service" basis for all CPT codes.
10. If, after the implementation of a software update, 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 BCBSNC contracts, State law, or standard of practice in North Carolina, and appropriate action will be taken.
11. 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:
 - a. Fraud, misrepresentation and other intentional misconduct,
 - b. Contractual requirements of certain self-funded groups,
 - c. Contractual requirements of certain Provider contracts,
 - d. Statutory or regulatory compliance,
 - e. Governmental program limitations,
 - f. Unsolicited or self-reported refunds.

This policy will apply to all BCBSNC insured programs and to self-funded groups where the group has contractually agreed to the limitation. BCBSNC will require its outside vendors to adhere to BCBSNC's payment recovery policies and procedures.

Policy Guidelines

BCBSNC may request medical records for determination of medical necessity. 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 medical necessity determination is included.

Policy Key Words

Key Words: *ADM9104*, pricing and adjudication principles, payment, bundling

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Medical Term Definitions

Not applicable

Policy Implementation/Update Information

- 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."

Medical 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 BCBSNC reserves the right to review and revise its medical policies periodically.