Blue Cross® and Blue Shield® of North Carolina (Blue Cross NC) | Healthy Blue + Medicare℠ (HMO-POS D-SNP)

Reimbursement Policy
Code and Clinical Editing Guidelines

Policy Number: **G-07016**

Policy Section: **Administration**
Last Approval Date: **03/25/2025**
Effective Date: **03/25/2025**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://bluecrossnc.com/providers/networks-programs/blue-medicare/healthy-blue-medicare**.

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Blue Cross NC applies Code and Clinical Editing Guidelines (CCEG) to evaluate claims for accuracy and adherence to accepted national industry standards and plan benefits unless provider, state, federal, or CMS contracts, and/or requirements indicate otherwise.

Blue Cross NC uses software products that ensure compliance with standard code edits and rules. These products increase the consistency of payment for providers by ensuring that correct coding and billing practices are followed. CCEG consists of the following measures:

- Code editing software, CMS National Correct Coding Initiative (NCCI) edits, and Outpatient Code Edits (OCE):
  - Code editing software is updated to conform to changes in coding standards.
  - National Correct Coding Initiative (NCCI) edits are updated according to CMS published updates:
    - PTP (procedure to procedure)
    - MUE (Medically Unlikely Edits)
- Clinical Criteria
- Licensed clinical medical review
- Claims processing platform

Per state requirements, the health plan publishes its use of specific commercial code editing software.

Blue Cross NC only customizes applicable CCEG measures due to compelling business reasons.

Blue Cross NC also uses a coding algorithm approach to automatically adjudicate Evaluation and Management claims based on the applicable level of complexity or severity in accordance with diagnosis codes reported on the claims.

CCEG measures are updated as applicable and as needed to incorporate new codes, code definition changes, and edit rule changes.

All claims submitted after the configuration implementation date, regardless of service date, will be processed according to up-to-date CCEG measures. No retrospective payment changes, adjustments, and/or requests for refunds will be made when processing changes are a result of new code editing rules within a module update. The member is not responsible and should not be

balance billed for any procedures for which payment has been denied or reduced as a result of CCEG measures.

Nonreimbursable
Blue Cross NC will not reimburse in the event of a conflict with CCEG.

Note: When a service unit exceeds an MUE, the claim line(s) will be denied.

Related Coding
Standard correct coding applies.

Policy History
- **03/25/2025:** Review approved and effective: updated Related Policies and Materials section, removed language for coding algorithm approach to automatically adjudicate Evaluation and Management claims
- **05/19/2023:** Review approved and effective: added language regarding CMS MUE
- **09/08/2022:** Review approved: policy template updated
- **01/01/2021:** Initial approval and effective

References and Research Materials
This policy has been developed through consideration of the following:
- CMS
- State contract
- State Medicaid

Definitions
General Reimbursement Policy Definitions

Related Policies and Materials
- Emergency Department Leveling of Evaluation and Management Services
- Global Surgical Package
- Maximum Units Per Day
- Modifier Usage
- Modifiers 50 and 51: Multiple and Bilateral Services
- Modifiers 52, 53, 73, and 74: Reduced and Discontinued Services
- Modifiers 59, XE, XP, XS, XU: Distinct Procedural Services
- Multiple Radiology Payment Reduction
- Professional Anesthesia Services
- Split-Care Surgical Modifiers