SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Member Provider Policy & Procedure Manual

5.7 CODE EDITING

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Member Provider Policy & Procedure Manual*. If Blue Cross and Blue Shield of Louisiana (Louisiana Blue) makes any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Member Provider Policy & Procedure Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.lablue.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.lablue.com/providers.

This manual is provided for informational purposes only and is an extension of your Member Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail our policies. Louisiana Blue retains the right to add to, delete from and otherwise modify the *Member Provider Policy & Procedure Manual* as needed. This manual and other information and materials provided are proprietary and confidential and may constitute trade secrets.

CODE EDITING

Claims-editing System

Claims-editing software allows for effective and consistent management of healthcare billing and reimbursement by identifying potentially incorrect coding relationships on submitted claims. System changes are based on a combination of national coding edits, CPT guidelines, specialty society guidelines, clinically-derived edits and federal regulations and Louisiana Blue policies.

- Our editing system manages reimbursement policy, coding policy, medical policy, benefit rules and industry standard coding guidelines.
- It helps ensure accurate and consistent payments in accordance with coding, billing, reimbursement and clinical policies.
- It manages compliance with standard coding and billing practices between various types of services, such as medical, surgical, lab, DME and radiology.

We have a claims-editing tool available in iLinkBlue under the "Claims" menu option that will allow you to access our code-editing system logic. View our *iLinkBlue User Guide* for more information on researching code combinations in the claims-editing system tool. It is available on our Provider page at www.lablue.com/providers >Resources >Manuals.

CODE EDITING: BILLING PRACTICES SUBJECT TO REDUCTION

Reductions in payment due to code editing are considered above allowable amounts and appear on the Payment Register/Remittance Advice in the above allowable amount column. These amounts are not collectable from the Louisiana Blue member.

Unbundling

Unbundling occurs when two or more CPT or HCPCS codes are used to describe a procedure performed when a single, more comprehensive code exists that accurately describes the entire procedure. The unbundled procedures are considered included in the proper comprehensive code as determined by Louisiana Blue and is included in the allowable charge of the comprehensive code. Louisiana Blue will provide benefits according to the proper comprehensive code.

Incidental Procedures

Incidental covered procedures, such as the removal of appendix at the time of other intra-abdominal surgery with no pathology, are not reimbursed separately. The incidental procedure requires little additional provider resources and/or is clinically integral to the performance of the more extensive procedure. The allowable charge for the primary procedure includes coverage for the incidental procedure(s). If the primary procedure is not covered, any incidental procedure(s) will not be covered.

Mutually Exclusive Procedures

Mutually exclusive procedures are two or more procedures that usually are not performed at the same session on the same patient on the same date of service. Mutually exclusive procedures also may include different procedure codes and descriptions for the same type of procedures in which the provider should be submitting only one of the codes. One or more of the duplicative procedures is not reimbursable as it should be reimbursed only one time.

Maximum Frequency

Louisiana Blue applies maximum frequency limitations to claims. The allowable will be adjusted to reflect the amount allowed for the updated units.

Rebundles

Rebundles occur when two or more codes are billed instead of one more appropriate comprehensive code. Provider can refile the correct, comprehensive code.

Multiple Procedures

Multiple procedures are procedures performed during the same session/visit. The primary procedure is reimbursed at the allowable charge while the secondary procedure(s) are reimbursed up to 50% of the allowable charge. Billing Modifier 50 will not affect the determination of the primary procedure on the claim.

Modifier 51 can be used to report multiple procedures; however, Louisiana Blue considers it an informational modifier.

Bilateral procedures are considered multiple procedures. To report single and multiple bilateral procedures use Modifier 50. If a session/visit includes a combination of procedures, one code should be used with a bilateral modifier rather than reporting each procedure separately. If procedures are coded separately, Louisiana Blue may bundle the procedures and apply the appropriate allowable charge.

EMERGENCY DEPARTMENT (ED) OUTPATIENT FACILITY E&M CODING POLICY

Effective for dates of service on and after Nov. 1, 2024, Louisiana Blue uses the Optum Emergency Department Claim (EDC) Analyzer™ tool to determine appropriate E&M coding levels for outpatient facility ED claims. This policy has been developed to promote coding consistency across facilities. The policy is in adherence with E&M coding principles established by the Centers for Medicare & Medicaid Services (CMS) requiring hospital ED facility E&M coding guidelines to follow the intent of CPT code descriptions and reasonably relate to hospital resource use.

The EDC Analyzer tool determines appropriate E&M coding levels based on data from the patient's claim including the following:

- Patient's presenting problem
- Diagnostic services performed during the visit
- Any patient complicating conditions

To learn more about the EDC Analyzer tool, please visit https://EDCAnalyzer.com.

This policy applies to all facilities, including freestanding facilities. Criteria that may exclude outpatient facility claims from these policies include, but are not limited to:

- Claims for patients who were admitted from the emergency department or transferred to another healthcare setting (skilled nursing facility, long-term care hospital, etc.)
- Claims for patients who received critical care services (99291, 99292)
- Claims for patients under the age of 2 years
- Claims with certain diagnosis codes that when treated in the ED most often necessitate greater than average resource usage, such as significant nursing time
- Claims for patients who expired in the ED

Facilities submitting claims for ED E&M codes may experience adjustments to reflect an appropriate level E&M code or may receive a denial, based on the reimbursement structure set forth in the applicable Louisiana Blue network agreement.