blue of california

Payment Policy

Frequency Editing	
Original effect date:	Revision date:
01/01/2011	03/04/2024

IMPORTANT INFORMATION

Blue Shield of California payment policy may follow industry standard recommendations from various sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT) and/or other professional organizations and societies for individual provider scope of practice or other coding guidelines. The above referenced payment policy applies to all health care services rendered by a professional provider billed on CMS 1500 forms and, when specified, to those billed on UB04 forms or their electronic equivalent. This payment policy is intended to serve as a general overview and does not address every aspect of the claims reimbursement methodology. This information is intended to serve only as a general reference regarding Blue Shield's payment policy and is not intended to address every facet of a reimbursement situation. Blue Shield of California may use sound discretion in interpreting and applying this policy to health care services provided in a particular case. Furthermore, the policy does not address all payment attributes related to reimbursement for health care services provided to a member. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy such as coding methodology, industry-standard reimbursement logic, regulatory/legislative requirements, benefit design, medical and drug policies. Coverage is subject to the terms, conditions and limitation of an individual member's programs benefits.

Application

Blue Shield of California uses claims processing logic based on Lyric® rationale to identify when a procedure code is reported either per date of service, or across dates of service, and exceeds the number of times indicated by description of the procedure, or when it exceeds the number of times it is clinically appropriate or possible to perform. When procedures or quantity of units are identified as billed inappropriately, the claims processing solution will deny the multiple line items; or deny the units exceeding the allowed frequency and replace with a new corrected line item showing the appropriate number of units or a more comprehensive code.

Policy

Blue Shield of California recognizes the following factors when identifying a frequency limitation.

- Claim lines containing procedure codes with "single" or "unilateral" in the description that have been submitted more than once per date of service and recommends replacement for all occurrences of the "single/unilateral" with the corresponding "multiple" or "bilateral"

code.

- Claim lines that contain procedure codes that have been submitted more than once per date of service, when the maximum allowance is defined as once per date of service.
- Claim lines where the MUE (facility outpatient and practitioner) has been exceeded for a CPT/HCPCS code, reported by the same provider**, for the same member, on the same date of service.
- The service is anatomically or clinically limited with regard to the number of times it may be performed per date of service.

** BSC follows CMS guidelines when applying MUE frequency limitation for Critical Care Evaluation and Management Services (99291 and 99292) and considers same provider as a physician of the same specialty within the same group practice bill and are paid as though they were a single physician.

Rationale

Blue Shield of California's frequency policy will identify when a procedure code is reported either per date of service, or across dates of service which exceeds the number of times indicated by description of the procedure, or when it exceeds the number of times it is clinically appropriate or possible to perform. When procedures or quantity of units are identified as billed inappropriately, the claims processing solution will deny the multiple line items; or deny the units exceeding the allowed frequency and replace with a new corrected line item showing the appropriate number of units or a more comprehensive code.

Reimbursement Guideline

Blue Shield of California will reference national or regional industry standards, such as Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and MUE (Medically Unlikely Edits) rules, and American Medical Association's (AMA) CPT guidelines, as coding standards and as guidance for payment policy. In claims payment scenarios where CMS and/or CPT reference is lacking or insufficient, the Payment Policy Committee (PPC) may develop customized payment policies that are based on other accepted or analogous industry payment standards and or expert input.

Resources
• **American Medical Association** https://www.ama-assn.org/ • **Centers for Medicare & Medicaid Services** https://www.cms.gov/

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Payment Policy.

Effective Date	Action	Action
01/01/2011	New Policy Adoption	Payment Policy Committee
08/03/2016	Maintenance	Payment Policy Committee
07/08/2017	Policy Revision	Payment Policy Committee
01/12/2018	Maintenance	Payment Policy Committee
08/03/2018	Maintenance	Payment Policy Committee
03/04//2024	Updated ClaimsXten vendor name from Change Healthcare to Lyric	Maintenance

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.

These Policies are subject to change as new information becomes available.