blue of california

Payment Policy

Global Component	
Original effect date:	Revision date:
07/08/2017	08/03/2018

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 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's Global Component Payment Policy applies when duplicate submissions of a total global procedure or its components are submitted for the same patient on the same date of service on separate claim lines or on different claims from the same provider or different providers.

CPT or HCPCS in this policy include codes, which are assigned a PC/TC Indicator 1 in the CMS Medicare Physician Fee Schedule (MPFS) Relative Value File. The CMS National Physician Fee Schedule Relative Value file directs that a global procedure includes reimbursement for both the professional and technical components of certain procedures. A single provider can bill for both components (global procedure), or different providers can each bill for different components. Claims for these types of procedures should only be paid up to the total of the global procedure (both technical and professional components combined). Any submission of the same procedure must be evaluated

against previous submissions to determine if any or all components of the procedure have already been paid. The current claim is adjusted accordingly.

Policy

This policy is applied across providers to claims with date of service on or after July 8, 2017.

Blue Shield of California considers that only one provider will be reimbursed, when duplicate submission occurs for the total global procedure or its components, which are submitted for the same patient on the same date of service on separate claim lines or on different claims.

When any provider reports a global procedure and the same or another provider reports the same procedure with a professional component (26) or technical component (TC) modifier on a different line or claim, the procedure reported with the 26 or TC modifier will not be eligible for reimbursement.

Blue Shield of California recognizes “anatomical modifiers” (i.e., LT/RT) and modifiers 59, XE, XS, XP, XU when billed appropriately; and considers for separate reimbursement.

Additionally, when the CMS’ National Physician Fee Schedule Relative Value File (NPFSRVF) designates that modifier 26 is applicable to a procedure code (PC/TC indicator of 1 or 6), and the procedure (e.g., radiology, laboratory, or diagnostic) has been reported by a professional provider with a facility-based place of service, the procedure code must be reported with modifier 26. If modifier 26 is not submitted the line will be denied and a new claim line will be added along with the missing modifier 26 and processed accordingly. Please refer to Blue Shield of California’s Professional Component Payment Policy for additional information regarding modifier 26.

Rationale

The Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value file directs that a global procedure includes reimbursement for both the professional and technical components of certain procedures. A single provider can bill for both components (global procedure), or different providers can each bill for professional and technical components separately. Claims for these types of procedures should only be paid up to the total of the global procedure (both technical and professional components combined). Any submission of the same procedure must be evaluated against previous submissions to determine if any or all components of the procedure have already been paid. The current claim is adjusted accordingly.

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/ama • **CMS: Medicare Physician Fee Schedule (MPFS) Relative Value File** https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/PhysicianFeeSched/PFS-Relative-Value- Files.html

Policy History

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

Effective Date	Action	Reason
07/08/2017	New Policy Adoption	Payment Policy committee
08/03/2018	Maintenance	Payment Policy Committee

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 an enrollee's contract.

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