blue of california

Payment Policy

Professional Component	
Original effect date:	Revision date:
09/20/2013	01/01/2023

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 does not pay for the technical component of certain procedures when billed by a professional provider in a facility place of service (21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56, and 61).

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.

Policy

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, only the professional component will be eligible for reimbursement. When CMS designates modifier 26 is applicable to a procedure, and it is reported by a professional provider for the technical component (modifier TC) in a facility setting, the claim line will be denied or if billed as a global service (no modifier) in a facility setting, the claim line will be replaced with a new line with the same procedure and modifier 26 will be added.

Example: CPT 78300

CMS Medicare Physician Fee Schedule (MPFS) Relative Value File designates that modifier 26 is applicable to procedure 78300.

Global Billing:
78300 is submitted as a global procedure (no modifier) by a professional provider in a facility setting (i.e., 21). The claim line will be replaced with a new line for procedure 78300 and modifier 26 will be added.

Technical Component Billing:
78300 is submitted for reimbursement of the technical component (modifier TC) by a professional provider in a facility setting (i.e., 21). The claim line will be denied.

Rationale

The professional component of a service is for physician work interpreting a diagnostic test or performing a procedure, which includes indirect practice and malpractice expenses related to that work. Modifier 26 is used with the billing code to indicate that the professional component is being billed. When a service is billed globally, the provider is reimbursed for the equipment, supplies, and technical support, as well as the interpretation of the results and the report. Facilities reporting such procedures on a UB are assumed to be billing the technical component. Therefore, a professional provider will be reimbursed for the professional component and not the technical component.

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
- **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	Reason
09/20/2013	New Policy Adoption	Payment Policy committee
09/20/2015	Revision	Payment Policy Committee
02/25/2017	Maintenance	Payment Policy Committee
07/08/2017	Revision	Payment Policy Committee
08/03/2018	Maintenance	Payment Policy Committee
01/01/2023	Updated example code as 78300	Payment Policy 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 an enrollee's contract.

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