FACILITY BILLING GUIDELINES

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Description

Blue Cross NC utilizes the guiding principles outlined below for outpatient facility claims editing. These principles may help practitioners anticipate and understand the likely outcome of claims submissions. Blue Cross NC follows coding edits that are based on industry sources, including, but not limited to; CPT® guidelines from the American Medical Association, specialty society organizations, and CMS including NCCI, OCE, and MUE.

Blue Cross NC follows the instruction and guidance of code and claim form issuers, including but not limited to CPT, HCPCS, UB-04, and ICD-10.

Policy

Blue Cross Blue Shield North Carolina (Blue Cross NC) will reimburse facility billing according to the criteria outlined in this policy.

Reimbursement Guidelines

The following scenarios are not reimbursable:

Service Descriptions	Reimbursement Guidance
All Services	For services provided to prisoners or members in state or local custody (defined as Condition Code 63), reimbursement will not occur unless modifier QJ is also appended to the codes indicating that certain exception criteria have been met. Bill types must be reflective of the services received and align with the location where the services were rendered.
Ambulance Services During Inpatient Admission	Ambulance services for date of service that is after the admission date and prior to the discharge date for any inpatient admission.
Annual Wellness Visit	Annual wellness visit (AWV) is considered a professional service, and there will be no separate reimbursement for a facility fee. If being provided in a facility setting, the bill type must be reflective of such.

Audiology Services, including: audiologic function test, evaluation and therapeutic services, and special diagnostic procedures.	Reimbursement will not occur when these services are performed in an outpatient rehabilitation facility.
Cardiac and Pulmonary Rehabilitation	Cardiac and pulmonary rehabilitation services will only be eligible for reimbursement when submitted with bill types representing hospital outpatient or critical access center.
Clinical Trial Services	Clinical trials that are performed in an outpatient facility, require three items to be included for proper processing of the claim: the appropriate clinical trial modifier (Q0 or Q1), condition code indicating qualifying clinical trial, and the appropriate bill type signifying outpatient hospital.
Corneal Tissue Processing, Preserving and Transporting	Corneal tissue processing, preserving and transporting should only be reported when corneal tissue is used in a corneal transplant procedure.
Devices, Implants, Blood Products, & Imaging Agents	Certain implants, devices, blood products, and imaging agents require the applicable procedure to also be billed. Blue Cross NC requires that the relevant associated procedure code for the implant, device, or imaging agent to be billed. Additionally, the related procedure must also be reimbursable, for the implant, device, or imaging agent to be separately reimbursable. For example, an imaging agent should not be billed without the requisite imaging procedure. In this example, the imaging agent will not be reimbursable without the related reimbursable procedure. Similarly, device-dependent procedures will not be eligible for reimbursement in the absence of a device. Blue Cross NC will not provide reimbursement for autologous blood collection, processing and storage on the same date as a transfusion as these codes are intended to be used when blood is collected but not transfused. Likewise, if Blue Cross received and adjudicated a claim for autologous blood collection, processing and storage, then the transfusion of the blood product will not be eligible for reimbursement on the same date of service.
Digital Breast Tomosynthesis (DBT) (G0279)	DBT is only eligible for reimbursement in the inpatient hospital, outpatient hospital, inpatient skilled nursing facilty (SNF), outpatient SNF, and outpatient critical access center. Bill types must be reflective of this. Additionally, DBT must be billed with the appropriate revenue codes.

Donor Services	Revenue code 0815 (Allogeneic stem cell acquisition/donor services) is only reimbursable when submitted with inpatient hospital, outpatient hospital or Special facilities-critical access hospital bill types.
Emergency Treatment and Labor Act (EMTALA) screening:	Reimbursement of revenue code 0452 requires the presence of 0451 on the same date of service. Evaluation and Management services using revenue code 0450 are not separately reimbursable when submitted with 0451 or 0452 on the same date of service.
Federally Qualified Health Center (FQHC) Services	Five visit codes (G0466-G0470) were established to be used by FQHC when submitting a claim for services under the prospective payment system (PPS). Only 1 unit of any FQHC visit or up to 3 units if providing a combination of FQHC visits will be eligible for reimbusement if reported on a single date of service. If billing for a combination of FQHC visits, the appropriate modifier must also be appended to the claim line. G0469 (FQHC visit, mental health, new patient) when reported for PPS payment will not be eligible for reimbursement if FQHC new patient visit code G0466 is also present on the claim.
Home Health	Home health services for date of service that is after the admission and prior to the discharge for any inpatient, skilled nursing facility, or swing bed hospital admission.
Hospital at Home (CMS Acute Hospital Care at Home)	Hospital at Home services are not eligible for reimbursement. If these services are provided, Blue Cross NC requires they be submitted with Revenue code 161 and Occurrence Span Code 82.
Hospital Observation Service and Hospital Emergency Department Visit	Reimbursement will not occur if either of these services are billed with Revenue codes 0960-0989 (professional fee) or modifier 26 as the codes are exclusive to facility billing only.
Hospice Services	Hospice services (Q5003-Q5008, Q5010) must be billed with an appropriate bill type. Services completed under hospice care will not be eligible for reimbursement if submitted on a hospice bill type indicating late charges. However, hospices may adjust finalized claims to add late charges within the normal timely filing period.
Outpatient Services During Inpatient Admission	Services, other than ambulance, that are rendered by an outpatient hospital and the date of service is

	after the inpatient admission date and prior to the discharge date, by any provider.
Professional Services:	Revenue codes 0960-0989 representing professional services are not eligible for reimbursement on a facility claim. These services are to be submitted on a CMS-1500 professional claim form.
Rural health clinic (RHC) services	RHCs are required to bill the appropriate revenue code representing a free standing clinic or behavioral health treatment/service and applicable HCPCS/ CPT® code for each qualifying preventive health, behavioral health, or medical service provided. Additional services provided in an RHC will not be eligible for reimbursement when billed with revenue codes other than the ones previously addressed. Only one qualifying medical visit is reimbursed per date of service (unless modifiers are appropriately appended) and, only one qualifying mental health visit is reimbursed per date of service. Additional medical or behavioral health services will not be eligible for reimbursement. A qualifying preventive health service, other than an initial preventive exam (G0402) is not reimbursed in addition to an RHC qualifying medical service, on the same date of service.
Self-Administered Drugs	Revenue code 0637 (Pharmacy - self-administered drugs) is not reimbursable when submitted without a HCPCS code.
Skin Substitute Procedures and Products	Billing for skin substitute application procedures are required to also include the appropriate high cost or low cost skin substitute products.
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	Ultrasound screening for AAA is only eligible for reimbursement in the following settings: inpatient hospital, outpatient hospital, inpatient SNF, outpatient SNF, RHC, freestanding clinic, and outpatient critical access center. Bill types must be reflective of this.

Rationale

Blue Cross NC enforces CMS guidance for purposes of this facility billing reimbursement policy and will provide reimbursement accordingly.

Billing and Coding

BlueCross BlueShield of North Carolina

Commercial Reimbursement Policy

Applicable codes are for reference only and may not be all inclusive For further information on reimbursement guidelines, please see the Blue Cross NC web site at **Blue Cross NC.**

Related policy

Bundling Guidelines

Modifier Guidelines

Outpatient Code Editor (OCE) Edits

Pricing & Adjudication Principles

Revenue Codes Requiring Procedure Codes, Facility

References

Healthcare Common Procedure Coding System (HCPCS)

American Medical Association, *Current Procedural Terminology* (CPT®)

Centers for Medicare & Medicaid Services CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge | CMS

Centers for Medicare & Medicaid Services NCDHHS COVID-19 Extension of Hospital at Home Program

Centers for Medicare & Medicaid Services CMS Manual Pub 100-20

History

6/1/2022	New policy developed. Medical Director approved. **Notification on 3/31/2022 for effective date 6/1/2022**. (eel)
6/30/2022	Clarification added: (CMS Acute Hospital Care at Home) Service Descriptions for Reimbursement Guidance: Hospital at Home services are not eligible for reimbursement. If these services are provided, Blue Cross NC requires they be submitted with Revenue code 161 and Occurrence Span Code 82. **Effective date 6/30/2022. (ckb)**
12/31/2022	Routine policy review. Alphabetized Service Descriptions. Minor revisions. (ckb)

Application

These reimbursement requirements apply to all commercial, Administrative Services Only (ASO), and Blue Card Inter-Plan Program Host members (other Plans members who seek care from the NC service area). This policy does not apply to Blue Cross NC members who seek care in other states.

This policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore, member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing, and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.