BlueNews℠ for Providers

BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

My Provider Enrollment Portal

My Provider Enrollment Portal is our new provider enrollment tool, which will be launched during the first quarter of 2022.

Highlights of the portal include:

- Quick and easy navigation with a new chat feature.
- The ability to upload and store documents until they are ready for submission.
- Automated statuses and notifications when additional information is needed.

For more details, be sure to review the 2022 Annual Provider Summit presentation online.

90-Day Provider Validation Requirements

Provider demographic data can change frequently throughout the year and in our networks. To be sure our members know where to find the right physicians or facilities for the care they need, it is vital that we validate the accuracy of their contact information regularly. As part of the No Surprises Act, set to go into effect on **Jan. 1, 2022**, providers are required to verify or update their demographic data at least **every 90 days**. This includes both individual physicians and facilities.

Validations should be completed using M.D. Checkup, which is in My Insurance Manager℠ (MIM) and the 90-day time frame will be based on the number of days since the last validation was made. If more than 90 days has passed since the provider's last validation, we are required to remove them from our directories.

M.D. Checkup can also be used if updates are needed. Once the changes have been made, we will have our directories updated with the new data within two business days of receipt.

Medicare Advantage Prior Authorization Updates

Effective **Jan. 1, 2022**, the below services will be included in the prior authorization requirements for our Medicare Advantage BlueCross Total℠, BlueCross Secure℠ and BlueCross Basic℠ plans:

- Medications covered under Medicare Part B, including but not limited to viscosupplementation for knee osteoarthritis (hyaluronan), monoclonal antibody treatments and other biologicals for multiple sclerosis, rheumatoid arthritis, psoriasis, inflammatory bowel disease or chronic migraine headaches

J1756 - Iron Sucrose	**J0897** - Denosumab
J7323 - Euflexxa®	**J7321** - Hyalgan®/Supartz®
J0885 - Epoetin Alfa	**J7324** - Orthovisc®
J1561 - Gamunex®-c/Gammaked™	**J1569** - Gammagard
J1459 - Privigen®	**J1745** - Infliximab
Q5115 - Truxima®	**J2916** - Na Ferric Gluconate
J0717 - Certolizumab Pegol	**J1750** - Iron Dextran
J7327 - Monovisc®	**J7605** - Arformoterol
J0178 - Aflibercept	**J2778** - Ranibizumab
J1439 - Ferric Carboxymaltos	**J2274** - Morphine
J9312 - Rituximab	**Q0138** - Ferumoxytol
J7325 - Synvisc®/Synvisc-One®	**J0881** - Darbepoetin alfa
J1568 - Octagam®	**J0517** - Benralizumab
J2350 - Ocrelizumab	**J2357** - Omalizumab
J2182 - Mepolizumab	**J1300** - Eculizumab
J7312 - Dexamethasone intra	**J9035** - Bevacizumab
J0585 - Onabotulinumtoxina	**J3489** - Zoledronic Acid
J2278 - Ziconotide	**J1602** - Golimumab
J9204 - Mogamulizumab-kpkc	**J2323** - Natalizumab
J0129 - Abatacept	

- Continuous glucose monitors, including but not limited to the Dexcom and Freestyle Libre systems

K0553	K0554

- Powered mobility, including but not limited to electric wheelchairs and scooters

K0013	K0800	K0898	E0986

- Durable medical equipment (DME), including but not limited to prosthetics, orthotics, braces and walkers in the amount of **$250 or more**

E0250	E0251	E0290	E0291	E0255
E0256	E0292	E0293	E0260	E0261
E0294	E0295	E0265	E0266	E0296
E0297	E0301	E0304	E0766	E2402
L0456	L0464	L0482	L0637	L0650
L0651	L0648	L2036	L0488	L0631
L1852	L0486	L1843	L0457	L1851
L1950	L1970	L1932	L1833	L1951
L1832	L2385	L0472	L1845	L1990
L0627	L0642	L2624	L1971	L1970
L1945	L1846	L1960	L2280	L2114
L1850	L2260	L2330	L5856	L5973

- Facility-based polysomnography (sleep study) — Unsupervised home studies are preferred unless there are specific complicating factors requiring sleep lab monitoring.

95807	95808	95810	95811

- Bariatric surgery

43644	43645	43770	43845	43846
43847	43775			

- LifeVest® external cardiac defibrillators

K0606	K0607	K0608	K0609	93745

- Inpatient level of care for nonemergent surgery

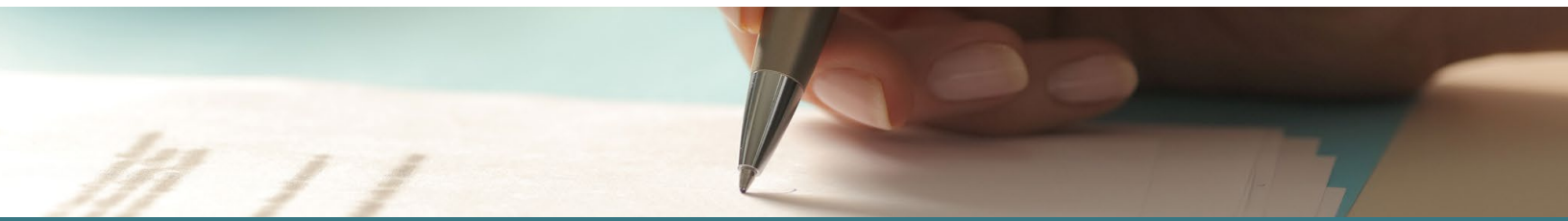
Methods for Requesting Prior Authorization

Medical Services

- My Insurance Manager
- Phone: 855-843-2325
- Fax: 803-264-6552

Behavioral Health Services

- Online: www.CompanionBenefitAlternatives.com
- Phone: 800-868-1032



Understanding ClaimsXten™

ClaimsXten was implemented in March 2019 and is a robust code-auditing software designed to ensure health insurance claims are coded properly. The software relies on clinically supported rules and logic influenced by national medical societies, current coding practices and the National Correct Coding Initiative (NCCI).

ClaimsXten contains rules, each of which consists of the logic necessary to execute a specific payment policy or guideline. Each rule has an associated set of clinical data that, when applied, results in an edit. The edit is a recommendation to deny, review, modify or allow a specific claim line.

Please be mindful that ClaimsXten does not follow only the Centers for Medicare & Medicaid Services (CMS) coding guidance. BlueCross aligns with CMS when possible, but there are times in which the alignment isn't necessary or warranted.

Do note the following:

- CMS applies edits BlueCross does not.
- CMS is a regional governmental payer, and BlueCross is a local private payer.
- NCCI is editing for CMS as a payer for claims that are paid by CMS.

To ensure claims follow the correct coding guidelines of ClaimsXten, providers are encouraged to:

- Review their current coding practices.
- Consult with their business partners who code and bill on their behalf to be sure proper coding is being used.
- Make sure all appropriate staff are up to date on correct coding guidelines.
- Identify any potential impacts and make the necessary changes.

Corrected Claims

After submitting a claim to BlueCross, you may notice a change is needed. In this instance, you will need to submit a corrected claim for processing. As a reminder, it is important to submit corrected claims properly to avoid receiving a duplicate denial due to the previous claim having already been filed.

To properly submit a corrected claim:

1. Frequency Code 7 (indicating an adjustment) should be placed in Box 22 of the CMS-1500 form (Resubmission Code).

This corresponds to the CLM05-3 segment in the 2300 Loop of the electronic claim file.

2. The BlueCross original claim number (ICN or DCN) should be placed in Box 22 of the CMS-1500 form (Original Ref. No.).

This corresponds to an REF segment with an F8 qualifier in the 2300 Loop of the electronic claim file.

3. A brief description for the reason of the adjustment (e.g., new service line, added modifier, etc.) should be placed in Box 19 of the CMS-1500 form (Additional Claim Information).

This corresponds to an NTE segment in the 2300 Loop of the electronic claim file.

4. All claim lines need to be processed, including existing lines, corrected lines or additional lines.

If filing a corrected claim through MIM, do the following:

1. Under the Patient Care menu, select Professional Claim Entry.
2. Select a plan and indicate whether the plan is the primary payer.
3. Select the billing location, rendering provider and/or referring provider when prompted. You can opt to choose a patient or manually enter the patient's information on the Patient Information page.
4. On the Claim Information page, select Replacement of Prior Claim from the Claim Type menu. Enter the prior claim number in the required filed.
5. Enter the new information from the line of your claim.
6. Include ALL lines that need to be processed, including existing lines, corrected lines or additional lines.
7. Once completed, select Continue.
8. Confirm the claim information is accurate and then select Submit.

Proper Use of Modifiers

Accurate coding and reporting of services on medical claims submitted to BlueCross and BlueChoice® HealthPlan is critical in assuring proper payment to providers. Modifiers play a vital role in this, as they are used to provide additional information necessary for processing claims. For this reason, it is important to understand how and when to append modifiers to claims.

Below are helpful tips on proper use of common modifiers used when coding for clinical situations. Clinical documentation should support the use of any modifier.

Modifier 25:

Modifier 25 should be used to report an evaluation and management (E/M) service on a day when another procedure or service is rendered to a patient by the same physician or other qualified health care professional.

Note: This modifier should not be used to report an E/M service that resulted in a decision to perform surgery; see Modifier 57. Also, the type of bundling a code pair falls under will also impact what modifier actually overrides the bundling. In some cases, no modifier override is possible, as the services that are bundled may not physically be possible to do or clinically possible to do together. Different types of bundling include same visit, mutually exclusive and ultimate parent.

Example

A patient visits the cardiologist due to discomfort in his chest while exercising. This patient has a history of high blood pressure. Once the physician completes the office visit, it is determined the patient needs a cardiovascular stress test, which is performed that day by the same physician.

Coding

The physician or qualified health care professional codes for the E/M (99202 – 99215) and the cardiovascular stress test (93015). The modifier 25 is appended to the E/M visit to indicate there was a separately identifiable E/M on the same day of the procedure.

Line 1 – 99213, 25

Line 2 – 93015

Modifier 50:

Modifier 50 should be used to report bilateral surgical procedures as a single unit of service. Do keep in mind that coding claims for surgical procedures performed bilaterally depends on:

- The CPT®/HCPCS Level II code descriptor.
- The bilateral indicator assigned to the CPT/HCPCS Level II codes (whether special payment rules apply).
- The nature of the service.

Note: Bilateral procedures that allow payment adjustment will be paid at 150 percent unless other contract provisions apply. Certain CPT/HCPCS codes are bilateral in nature and thus should not be submitted with a modifier 50, as the code assumes the service was done bilaterally. The use of RT and LT has no impact on services performed bilaterally in terms of payment. RT and LT modifiers are descriptive modifiers only.

Example

A patient has breast cancer that has spread, and as a result, the patient must have a double mastectomy performed.

Coding

The physician or qualified health care professional codes for mastectomy (19303). The modifier 50 is appended to the code to indicate service was performed bilaterally.

Line 1 – 19303, 50

Continued on page 5

Modifier 57:

Modifier 57 should be used to report an E/M service when the E/M results in the decision to go to surgery. This can take place the day of or the day before the procedure.

Example

A patient visits the emergency room with abdominal pain and fever. After consulting with the patient, the physician determines an emergency appendectomy is needed and performs the procedure that day.

Coding

The physician or qualified health care professional codes for the E/M and the appendectomy (44950). The modifier 57 is appended to the E/M visit to indicate service resulted in the decision to go to surgery.

Line 1 – 99243, 57

Line 2 – 44950

Modifier 59:

Modifier 59 should be used to report procedures or services that are not normally reported together but are appropriate under the circumstances. However, if a more appropriately established modifier is available, it should be used rather than modifier 59. Modifier 59 should only be used when a more descriptive modifier is not available and the use of modifier 59 best explains the circumstances.

Note: The X series of modifiers aligns with modifier 59 and provides more granularity in reporting the actual clinical situation. Also, the type of bundling a code pair falls under will also impact what modifier actually overrides the bundling. In some cases, no modifier override is possible as the services that bundled may not physically be possible to do or clinically possible to do together. Different types of bundling include same visit, mutually exclusive and ultimate parent.

Example

A patient visits the neurologist to have a nerve conduction study performed on separate nerves.

Coding

The physician or qualified health care professional codes for the nerve conduction studies (95907 and 95908). The modifier 59 is appended to one of the codes to indicate that service was performed on separate nerves.

Line 1 – 95907, 59

Line 2 – 95908

Modifier 76:

Modifier 76 should be used to report that a procedure or service was repeated subsequent to the original procedure or service by the same physician or qualified health care professional.

Note: The modifier 76 is only applicable to code ranges 10021 – 69990, 70010 – 79999, 90281 – 99199 and 99500 – 99607.

Example

A patient visits the hospital with pain in her lower abdomen that radiates to her back. The physician decides to perform an ultrasound for flank pain and sends the patient home with pain medicine. The patient returns the same day and sees the same physician who performs another ultrasound for possible renal issues.

Coding

The physician or qualified health care professional codes for both ultrasounds. The modifier 76 is appended to one of the codes to indicate that service was repeated on the same day by the same physician or qualified health care professional.

Line 1 – 76700

Line 2 – 76700, 76

Modifier 77:

Modifier 77 should be used to report that a procedure or service was repeated subsequent to the original procedure or service by another physician or qualified health care professional.

Note: The modifier 77 is only applicable to code ranges 10021 – 69990, 70010 – 79999, 90281 – 99199 and 99500 – 99607.

Example

A patient is involved in a car accident and visits the hospital because of chest pain that spreads to her jaw and arm. The physician performs an EKG and notes an arrhythmia. Due to other injuries that cannot be treated at this hospital, she is transferred to another facility. As the result of increased pain, the physician in the emergency room performs another EKG to rule out cardiac arrest.

Coding

The physician or qualified health care professional codes for the EKG (93000). The modifier 77 is appended to the code to indicate that service was repeated on the same day by another physician or qualified health care professional.

Line 1 – 93000, 77

U0005 Reimbursement

BlueCross and BlueChoice® continue to monitor the status of the COVID-19 virus to ensure our provider community remains abreast of any changes in policy or procedure related to the care of your patients, our members.

The following code set is recognized by CMS as valid services for COVID-19 testing:

U0003 – Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-COV-2) (Coronavirus disease (COVID-19)), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R

U0004 – 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types, or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R

U0005 – Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-COV-2) (Coronavirus disease [COVID-19]), amplified probe technique, CDC or non-CDC, making use of high-throughput technologies, completed within two calendar days from date and time of specimen collection

Regarding the reimbursement of U0005, although CMS as a payer elected to cover U0005, commercial payers are not required to align with this coverage.

CMS' decision to reimburse U0005 has several factors to consider:

1. Reimbursement for COVID-19 diagnostic tests (U0003 or U0004) run on high-throughput technology was lowered to $75 from $100.

2. Additional reimbursement for the service U0005 applies if:

- The test is completed in two calendar days or less from the date of specimen collection.
- The majority of the provider's COVID-19 diagnostic tests (U0003 or U0004) performed using high-throughput technology in the previous calendar month were complete in two calendar days or less for all their patients.

To ensure proper time frames for reimbursement are met, CMS can perform audits of the laboratory's records to support the billing of U0005. If the above criteria are met, CMS will make an additional $25 add-on payment for U0005, bringing the total reimbursement of U0003 or U0004 and U0005 to $100.

For laboratories that do not meet the criteria, CMS will only reimburse $75 for U0003 or U0004.

BlueCross and BlueChoice, on the other hand, did not elect to lower the amount of the diagnostic tests, and both plans continue to reimburse codes U0003 or U0004 at $100. Therefore, no additional payment would be warranted for U0005.

COVID-19 Vaccine Updates

BlueCross and BlueChoice continue to monitor the COVID-19 virus to make sure our provider community remains aware of any changes that may occur.

Ages 5 – 11

On Oct. 29, 2021, the vaccine was approved for children 5 through 11 years of age. The CPT code set has been updated with the following new codes for the vaccine product (Pfizer) and vaccine administration. As a reminder, the vaccine itself is covered by the government and should not be submitted for payment.

Vaccine Code

91307 – Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use

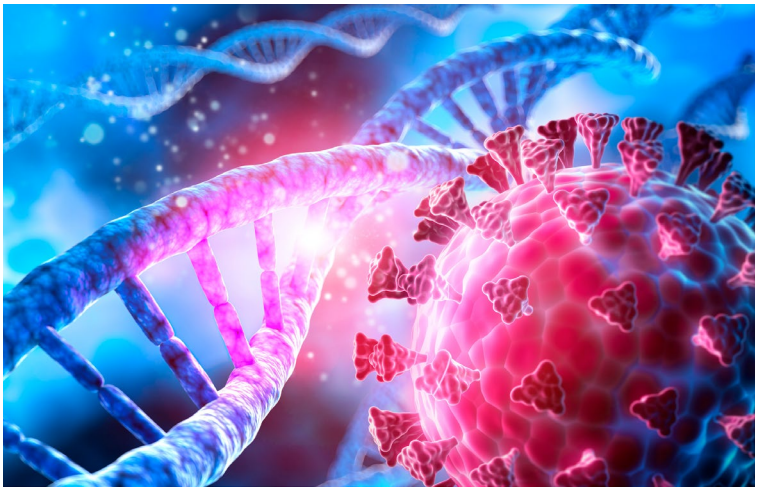
Vaccine Administration Codes

0071A – Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; first dose

0072A – Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; second dose

Booster Shots

The administration of booster shots is covered at no cost share to members, and claims should be submitted with valid and appropriate coding for reimbursement.



Accident Questionnaire

Has your patient received a request for an accident questionnaire? Accident questionnaires are automatically generated to the member if there are trauma-related diagnosis codes on the claim.

Often, the questionnaire is overlooked by the member or it is returned incomplete and without sufficient information to determine if the service was related to an event for which a third party may be responsible.

In both scenarios, multiple attempts are made to reach the member, as it is ultimately the member's responsibility to return the completed questionnaire with all required information. For this reason, we ask that you allow the member at least 60 days to respond and for us to complete our review of the submitted information.

See how you can help here.

Welcome to the Team!

This quarter, we would like to welcome a new team member to Provider Relations and Education. She brings a wealth of knowledge and skills that will make her a great asset.

NAME: Cynthia Brown

TITLE/RESPONSIBILITIES: Provider Relations Consultant

Hometown: Bishopville, South Carolina

Years with BlueCross: 26

Brief bio: Cynthia is a graduate of South Carolina State University, where she earned a bachelor's degree in business management with a minor in marketing. She has two children, Ashlyn (a senior at South Carolina State University) and Kerrington (a junior at Lee Central High School). Cynthia has been employed with the company for 26 years and has had the opportunity to gain a vast amount of experience and meet some great individuals. In addition to working with BlueCross full time, she is a co-owner of a towing service (C&S Towing) and a part-time travel agent (Global Getaways). Cynthia is a foodie and enjoys cooking and baking. She also loves to travel, read, shop and spend time with her children.

Need To Get in Touch With Provider Relations and Education?

Provider advocates are always eager to assist you. If you have a training request, please contact your county's designated provider advocate by using the **Provider Advocate Training Request Form**. For questions about an ongoing education initiative or a recent news bulletin, submit the **Provider Education Contact Form**. These forms are located on the Provider Advocates page of our provider websites.

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