Blue Cross and Blue Shield of Georgia

Medicare Advantage Reimbursement Policy Changes

Summary of change: Blue Cross and Blue Shield of Georgia (BCBSGA) Medicare Advantage reimbursement policies have been updated, effective January 01, 2015. These policies apply to participating providers who serve Individual BCBSGA Medicare Advantage business. A non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates. To view the updated BCBSGA Medicare Advantage reimbursement policies, visit the provider self-service website at www.bcbsga.com. BCBSGA Medicare Advantage Employer Group Retiree business will not be affected by this update.

What does this mean to you?
Policy changes will impact the Individual BCBSGA Medicare Advantage business, which will be moving to a different claims processing platform. Please refer to the reimbursement policy website, your provider manual, and/or your provider contract as a guide for reimbursement criteria. These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member’s BCBSGA Medicare Advantage benefit plan. The determination that a service, procedure, item, etc. is covered under a member’s benefit plan is not a guarantee you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions.

Reimbursement policies undergo reviews every two years for updates to federal or CMS contracts and/or requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a BCBSGA Medicare Advantage business decision. When there is an update, the most current policies are published on the provider self-service website.

BCBSGA Medicare Advantage Employer Group Retiree business will remain on the current claims processing platform. Members under an Employer Group Retiree plan will have one of the following prefixes on their member card:

   FKB  JQF  JWM  VZM  VZP  WGK  WMN  WSP
   XDK  XDT  XGH  XGK  XKJ  XVJ  XVL  YCG
   YGJ  YGS  YLR  YLV  YRA  YRE  YRS  YRU

Why is this change necessary?
BCBSGA updated the BCBSGA Medicare Advantage reimbursement policies in order to streamline our Medicare Advantage business, improve our overall efficiency, and better align with CMS.

What if I need assistance?
The following table highlights some of the changes to the reimbursement policies. The complete set of policies is available at [www.bcbsga.com](http://www.bcbsga.com). If you have questions, please visit the provider self-service website or call the number on the back of the member’s ID card.

These changes apply only to Individual BCBSGA Medicare Advantage Business. The Employer Group Retiree Business will maintain current policies. Please refer to the complete list of reimbursement policies on the reimbursement policy website, your provider manual, and/or your provider contract as a guide for reimbursement criteria. These policies apply to participating providers unless provider, federal, or CMS contracts and/or requirements indicate otherwise.

<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Prior to January 1, 2015</th>
<th>As of January 1, 2015</th>
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<tr>
<td>Allergy Treatment: Immunotherapy</td>
<td>No previous reimbursement policy</td>
<td>BCBSGA Medicare Advantage allows reimbursement of allergy immunotherapy. Claims billed for more than 240 doses during a 12-month period will be denied.</td>
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<td>Professional Anesthesia Services</td>
<td>When Modifier AD is appended to a claim, the reimbursement percentage is based on the 3 base units. This rate is determined by the Conversion Factor x 3 regardless of the procedure base units reported. BCBSGA allows additional reimbursement for services reported with physical status modifiers P3, P4, and P5.</td>
<td>When Modifier AD is appended to a claim, reimbursement is based on 100 percent of the applicable fee schedule or contracted/negotiated rate for up to three base units for anesthesiologists who supervise three or more concurrent or overlapping procedures. BCBSGA Medicare Advantage does not reimburse for the use of physical status modifiers or qualifying circumstances codes denoting additional complexity levels.</td>
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<td>Assistant at Surgery (Modifiers 80/81/82/AS)</td>
<td>Assistant Surgeon services reported with Modifier AS will be eligible for reimbursement at 16 percent of the maximum allowance under the applicable physician</td>
<td>Assistant Surgeon services reported with Modifier AS will be eligible for reimbursement according to CMS reimbursement guidelines, currently 13.6 percent.</td>
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<tr>
<td>Claims Timely Filing: Participating and Non-Participating</td>
<td>No previous reimbursement policy</td>
<td>BCBSGA Medicare Advantage allows reimbursement of claims for covered services for covered members using appropriate claims timely filing requirements. BCBSGA Medicare Advantage follows the standard of 12 months for participating and non-participating providers and facilities.</td>
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<td>Consultations</td>
<td>BCBSGA recognizes consultation services, which are divided into two sections based on place of service: office or other outpatient consultations and inpatient consultations.</td>
<td>BCBSGA Medicare Advantage does not recognize office, outpatient or initial inpatient consultation codes.</td>
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<td>Diagnoses Used in DRG Computation</td>
<td>No previous reimbursement policy</td>
<td>BCBSGA Medicare Advantage ensures that the diagnosis and procedure codes that generate the Diagnosis Related Groups (DRG), and therefore the hospital invoice, are accurate, valid and sequenced in accordance with national coding standards and specified guidelines. BCBSGA Medicare Advantage performs DRG audits to determine that the diagnostic and procedural information that led to the DRG assignment is substantiated by the medical record.</td>
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<tr>
<td>Documentation Standards for Episodes of Care</td>
<td>No previous reimbursement policy</td>
<td>BCBSGA Medicare Advantage requires that, upon request for clinical documentation to support claims payment for services, the provided information should identify the member, be legible, and reflect all aspects of care. This policy outlines the minimum elements needed in order for documentation for episodes of care to be considered complete, and instructs providers to refer to the standard.</td>
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data elements to be included for specific episodes of care as established by The Joint Commission (TJC).

Other documentation not directly related to the member, but relevant to support clinical practice, may be used to support documentation regarding episodes of care; examples are listed within the policy. BCBSGA Medicare Advantage may request providers submit additional documentation to support their claims. If documentation is not provided following the request or notification or does not support the services billed for the episode of care, BCBSGA Medicare Advantage may deny the claim and recover and/or recoup monies previously paid on the claim.

<p>| Drug and Injectable Limits | No previous reimbursement policy | Reimbursement will be considered up to the Clinical Unit Limits (CUL) allowed for the prescribed/administered drug. We use the CMS Medically Unlikely Unit (MUE) value. When there is no MUE assigned by CMS, identified codes will have a CUL assigned or calculated based on the prescribing information, The Food and Drug Administration, and established reference compendia. Claims that exceed the CUL will be reviewed for documentation to support the additional units. If the documentation does not support the additional units billed, the additional units will be denied. |
| Inpatient Facility Transfers | No previous reimbursement policy | BCBSGA Medicare Advantage allows payment for services rendered by both the sending and the receiving facility when a patient is admitted to one acute care facility and subsequently transferred to another acute care facility for same episode of care. In the absence of federal guidelines regarding facility transfers payment, transferring facilities will receive a calculated per diem rate based on length of stay not to exceed the amount that would have been paid if the patient had been discharged to another setting, and receiving facilities will receive full DRG payment. This policy only affects those |</p>
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<th>Modifier 62: Co-Surgeons</th>
<th>63 percent of the maximum allowance is reimbursed for each of the two operating surgeons with the appended 62 modifier.</th>
<th>BCBSGA outlines when various obstetric services are included in the global reimbursement for obstetric services or when these services are eligible for separate reimbursement. Reimbursement to each surgeon is based on 62.5 percent of the applicable fee schedule or contracted/negotiated rate.</th>
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<tr>
<td>Modifier 66: Surgical Teams</td>
<td>Surgical Team services are identified by appending the Modifier 66 to the designated CPT code(s).</td>
<td>Each physician participating in the surgical team must bill the applicable procedure code(s) for their individual services with Modifier 66. If any or all physicians participating in the surgery fail to use the modifier appropriately, claims may be denied or pended for duplicate or suspected duplicate services, respectively.</td>
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<td>Modifier 76: Repeat Procedure by the Same Physician</td>
<td>A claim may be reviewed to determine the eligibility for separate reimbursement for the repeated procedure code.</td>
<td>Providers must submit supporting documentation for the use of Modifier 76 with the claim. If a claim is submitted with Modifier 76 without supporting documentation, the claim will be denied.</td>
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<td>Modifier 77: Repeat Procedure by Another Physician</td>
<td>A claim may be reviewed to determine the eligibility for separate reimbursement for the repeated procedure code.</td>
<td>Providers must submit supporting documentation for the use of Modifier 77 with the claim. If a claim is submitted with Modifier 77 without supporting documentation, the claim will be denied.</td>
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| Portable/Mobile/Handheld Radiology Services | No previous reimbursement policy | BCBSGA Medicare Advantage allows reimbursement for portable/mobile radiology services when furnished in a residence used as the patient’s home if ordered by a physician and performed by qualified portable radiology suppliers. Portable/mobile radiology studies should not be performed for reasons of convenience. Medicare Advantage allows preventive screenings performed by portable/mobile radiology studies for routine purposes.

Reimbursement is based on the applicable fee schedule or contracted/negotiated rate for the radiological service, and transportation and setup components with the use of applicable modifiers; transportation and setup component reimbursement guidelines are outlined within the policy. The policy also addresses reimbursement for the use of handheld radiology instruments. |
| Preadmission Services for Inpatient Stays | No previous reimbursement policy | BCBSGA Medicare Advantage allows reimbursement for applicable services for a covered member prior to admission to an inpatient hospital. For admitting hospitals, applicable preadmission services are included in the inpatient reimbursement for the three (3) days prior to and including the day of the member’s admission, and therefore are not separately reimbursable expenses. For other hospitals or units (e.g. children’s hospitals, psychiatric hospitals), applicable preadmission services are included in the inpatient reimbursement within one (1) day prior to and including the day of the member’s admission and, therefore, are not separately reimbursable expenses. |
| Prosthetic and Orthotic | The replacement of a DME item may be necessary | BCBSGA Medicare Advantage allows reimbursement of prosthetic and orthotic |
| Devices | through normal wear and tear. | devices and outlines in this policy their reimbursement methodology for these devices. For example, reimbursement is allowed for replacement of prosthetic and orthotic devices due to irreparable wear in consideration of the reasonable useful lifetime of the device of not less than 5 years based on when the equipment is delivered to the member, among other criteria listed in the policy. |
| Reimbursement for Reduced and Discontinued Services | No previous reimbursement policy | BCBSGA Medicare Advantage allows reimbursement to professional providers and facilities for reduced or discontinued services when appended by the appropriate modifier. When Modifier 73 is appended, reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. When Modifier 74 is appended, reimbursement is 100 percent of the applicable fee schedule or contracted/negotiated rate. |
| Scope of Practice | No previous reimbursement policy | BCBSGA Medicare Advantage allows reimbursement for services that are within the provider's scope of practice under state law in accordance with CMS guidelines. The provider shall be licensed in or hold a license recognized in the jurisdiction where the patient encounter occurs. |
| Split-Care Surgical Modifiers | For Modifier 56, reimbursement will be calculated at 10 percent of the applicable surgical reimbursement maximum allowance. | BCBSGA Medicare Advantage does not allow separate reimbursement for Modifier 56. |
| Unlisted or Miscellaneous Codes | No previous reimbursement policy | BCBSGA Medicare Advantage allows reimbursement for unlisted or miscellaneous codes (a.k.a. Not Otherwise Classified (NOC) codes). Unlisted or miscellaneous codes should only be used when an established code does not exist to describe the service, procedure, or item rendered. Claims submitted with unlisted or miscellaneous codes must contain the following information and/or documentation for consideration during review: a written description, office notes, or operative report |
| | describing the procedure or service performed; an invoice and written description of items and supplies; and/or the corresponding National Drug Code (NDC) number for an unlisted drug code. |

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