CLINICAL PAYMENT AND CODING POLICY

If a conflict arises between a Clinical Payment and Coding Policy (CPCP) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), ICD-10 CM and PCS, National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Outpatient Facility and Hospital Claims: Revenue Codes Requiring Supporting CPT, HCPCS and/or NDC Codes

Policy Number: CPCP018
Version 1.0
Clinical Payment and Coding Policy Committee Approval Date: October 27, 2022 Plan
Effective Date: February 1, 2023 (Blue Cross and Blue Shield of Texas Only)

Description

This policy does not apply to Inpatient claims.

The Plan requires outpatient facility providers and hospitals to indicate the most appropriate Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) code(s), and National Drug Codes (NDC) in addition to the revenue code for all electronic outpatient facility claims.

Reimbursement Information:

All electronic claims submitted by an outpatient facility provider or hospital must include a supporting HCPCS, CPT or NDC code with a revenue code unless otherwise specified in the provider contract. Revenue codes and procedure code combinations that are submitted on outpatient claims should reflect the services that were provided to the member on that date of service. These codes should be submitted on the same line for accurate claims processing. If more than one HCPCS, CPT or NDC code is needed for a revenue code, the revenue code should also appear on a separate line.

The plan reserves the right to request supporting documentation. Claim submissions that do not adhere to coding and billing policies may delay or impact claims processing and reimbursement. Claims may be reviewed on a case-by-case basis.

A revenue code and corresponding supporting code must be compatible.

The plan may deny an outpatient facility and hospital claim if it is submitted without the corresponding appropriate code(s) when submitted on the following bill types. If the claim has been denied, it may be resubmitted with the correct supporting code.

- Bill Types: 12x, 13x, 14x, 74x, 75x and 76x

Some revenue codes that are intended for inpatient hospital settings are not appropriate when billing for outpatient hospital claims by a facility.

National Drug Codes (NDC)

- For voluntary reporting and clinical encounter purposes, NDC information may be submitted with the related revenue or CPT/HCPCS codes as additional information when NDC information is not contractually required.

Electronic claim transactions for NDC data (ANSI 837I)

Field Name	Field Description	Loop ID	Segment
Product ID Qualifier	Enter **N4** in this field	2410	LIN02
National Drug Code	Enter the 11-digit NDC billing format assigned to the drug administered	2410	LIN03
National Drug Unit Count	Enter the quantity (number of NDC units)	2410	CTP04
Unit or Basis for Measurement	Enter the NDC unit of measure for the prescription drug given (**UN**, **ML**, **GR**, or **F2**)	2410	CTP05

Paper claim transactions for NDC data (CMS-1500 or UB-04)

Professional Paper Claims CMS-1500: In the shaded portion of line-item field 24A-24G, enter NDC qualifier N4 (left-justified), immediately followed by the NDC. Enter one space for separation. Next enter the appropriate qualifier for the correct dispensing NDC unit of measure (UN, ML GR or F2). Following this, enter the quantity (number of NDC units up to three decimal places).

See example below:

N4	00409477702	ML	600.000
NDC Qualifier	11-digit NDC	Unit of Measure	Quantity

Institutional Paper Claims UB-04: In line-item field 42-46, enter the appropriate drug-related revenue code in field 42, report the NDC qualifier N4 (left-justified), immediately followed by the 11-character NDC in the 5-4-2 format (no hyphens). Immediately after the last digit of the NDC, enter the appropriate qualifier for the correct package size, NDC unit of measure (UN, ML, GR or F2). Following this, enter the quantity (number of NDC units up to three decimal places).

See example below:

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE
636	N400409477702ML600.000	J0744

N4	00409477702	ML	600.000
NDC Qualifier	11-digit NDC	Unit of Measure	Quantity

The Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS) Integrated Outpatient Code Editor (I/OCE) maintains a current list of codes that require HCPCS. For the most up-to-date list, providers should refer to the CMS website.

References:

Centers for Medicare and Medicaid Services (CMS), Outpatient Code Editor (OCE)

https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit

National Council for Prescription Drug Programs (NCPDP) Standards

https://standards.ncpdp.org/Access-to-Standards.aspx

Policy Update History:

Approval Date	Description
07/12/2018	New policy
06/24/2019	Annual Review
06/16/2020	Annual Review, Disclaimer update
10/30/2020	Added revenue code 078x
12/01/2021	Annual Review
10/27/2022	Annual Review