JANUARY–FEBRUARY 2021

BCN Provider *News*

Clinical editing billing tips

Billing for monthly monitoring and management codes

CPT offers a number of options for billing monthly monitoring and treatment management services. These services include, but are not limited to:

- Digitally stored data services/remote physiologic monitoring
- Remote physiologic monitoring treatment management services
- Care management services
- Psychiatric collaborative care management services
- Transitional care management services
- General behavioral health integration care management

Each set of codes has a detailed section guideline for proper reporting. Some of the codes include specific instructions about what can or can't be billed together. For example, *99457 (remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes), states *Do not report *99457 in conjunction with *93264, *99091.* If those two codes are billed by the same provider, or another provider in the same practice with the same specialty, the second claim will deny. If this happens, check the billing guidelines and adjust accordingly.

There may be some circumstances in which a clinical edit denial occurs on two codes that overlap time limitations. We make sure the time requirement for each code is not duplicated from one code to the other. If the documentation supports the two services were performed, without overlap of requirements, you should file an appeal. Upon review of the documentation, we'll overturn the edit for payment if the criteria of both services have been met.

Clinical editing appeal submission reminders

We've made minor changes to the clinical editing appeal process over the last few years with updated forms, new explanation codes and faxing requirements.

Please review the tips below to help expedite your appeal response:

- Appeals should be submitted within 180 days of the original appeal.
  - o If there is doubt about an edit, or you are working with a provider consultant, continue to submit the appeal while working through the question at hand.
- Submit all related documentation supporting the codes submitted on the claim, not just the service being appealed. This may include office records, radiology notes or other records depending on the service being appealed.
- Complete all required fields on the appeal form.
  - o Contact information, phone number and addresses are frequently omitted. We'll contact providers if we have questions or need additional information to make a decision.
- Submit each appeal separately with the appeal form as the first page. Our system automatically recognizes the appeal form as Page 1. Faxing more than one appeal at a time can cause delays in appeal processing. We do recognize this may be inconvenient, but it helps speed processing time.
- Don't submit an appeal more than once if you do not receive a decision.

Cont.

 W002979

Clinical editing billing tips *Cont.*

- We make decisions on appeals within 30 to 45 days of receipt. Contacting providers, completing additional research and review and obtaining decisions from other departments within Blue Care Network may require additional time.
- Contact customer service if you don't receive a decision in 30 to 45 days. Sending multiple submissions causes an increase in inventory and causes delays in reviewing the appeals. Appeals are processed in the order received.

For additional information on clinical editing and the complete appeal process:

- Log in to Provider Secured Services at **bcbsm.com**.
- Go to BCN Provider Publications and Resources.
- Click *Billing/Claims* in the left navigation.
- Click *Appealing a BCN clinical editing denial* under Clinical editing resources.

