

Blue Shield Report

A NEWSLETTER FOR PROFESSIONAL PROVIDERS AND THEIR STAFF MEMBERS

May 3, 2000

S-13-00

CLAIM CHECK UPDATE

- **Fiberglass Casting Billing**
- **Modifier 50**
- **Professional and Technical Component Billing**
- **Assistant Surgery Modifier Use**
- **Miscellaneous Items and Reminder**

In our March 15, 2000 newsletter (S-4-00), we announced the upcoming implementation of a new claims software package called Claim Check. We are anticipating an implementation date of May 6, 2000. There are additional changes we need to communicate prior to this implementation. Those changes are as follows:

- **FIBERGLASS CASTING:** It will no longer be necessary to submit claims for fiberglass casting with modifier 22 and a notation that fiberglass casting material was used. We have programmed the new system to automatically allow the additional reimbursement regardless of the type of material used.

NOTE: Casting supplies (A4580 and A4590) are processed as content of service. Reimbursement will not be made for these codes in addition to casting.

- **MODIFIER 50:** When using modifier 50 to indicate a bilateral procedure, other site-specific modifiers are not needed. For example, if a bilateral breast biopsy was done, submit CPT 19100 with modifier 50. Do not include any other site-specific modifiers.

QUESTIONS:

If you have questions, please contact your Professional Relations Representative, or the Professional Relations Hotline at **1-800-432-3587**, or in the Topeka area, **785-291-7060**.

OUR WEB ADDRESS:

<http://www.bcbsks.com>

ACKNOWLEDGEMENT:

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- **PROFESSIONAL AND TECHNICAL COMPONENTS BILLED BY THE SAME PROVIDER:** When both the professional and technical components are performed by the **same** provider, please bill the total component as one line item using the all-inclusive code. If these are to be billed as two line items with the 26 and TC modifiers, the second line item will be denied with the Remark Code RMW- "Benefits denied. The units billed exceed the maximum number of units allowed."

- **ASSISTANT SURGERY MODIFIERS:** Claims filed with modifier AS, indicating assistant surgery provided by a Physician Assistant (PA) or Nurse Practitioner (ARNP), will be converted during processing to modifier 80. The remittance advice will also report the 80 modifier versus the modifier used when the claim was filed.

MISCELLANEOUS ITEMS AND REMINDERS

- ◆ **MODIFIER 22:** For services requiring individual consideration, file with modifier 22 and **include supporting medical documentation.** Notations in Box 19 will not be accepted in place of supporting medical documentation.

- ◆ **CPT CODE 69210:** As a reminder, procedure code 69210, Removal impacted cerumen, is content of service when billed with an Evaluation and Management Code.

- ◆ **HCPCS CODES A9502 AND A9505:** In the MAC-2-99 newsletter dated January 31, 2000, page 5, it was stated that contrast agents should be billed using HCPCS A9502 or A9505 with the procedure code. It also stated that the contrast agents are no longer content of service of procedure codes 78465, 78472 and 78473. Claims that include type of service codes should report type of service code 4 with HCPCS A9502 and A9505.