Overview

The following is a description of the basic fee schedule methodology used to reimburse professional providers and some ancillary providers. In general, this reimbursement method is tied to the filing of a CMS-1500 claim form for services provided as designated by Current Procedural Terminology (CPT®) or HCPCS codes.

Note: For facility provider reimbursement, see Section 6, Facility Providers and Ancillary Providers

CPT copyright 2012 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.
# Table of Contents

Overview.................................................................................................................................... 1
Table of Contents ....................................................................................................................... 2
5.1 Fee Schedule ....................................................................................................................... 3
   5.1.1 Overview ....................................................................................................................... 3
   5.1.2 Fee Schedule Requests .............................................................................................. 3
   5.1.3 Reimbursement for Specific Services ....................................................................... 3
5.2 Anesthesia Guidelines ........................................................................................................... 5
   5.2.1 Overview ....................................................................................................................... 5
   5.2.2 Consultative, Diagnostic, and Therapeutic Services ...................................................... 5
   5.2.3 Physical Status Modifiers and Qualifying Circumstances ............................................. 5
5.3 Pricing Modifiers ................................................................................................................ 6
5.4 Professional Multiple Surgery Guidelines ........................................................................... 7
   5.4.1 Multiple Procedures, Same Operative Session ............................................................ 7
   5.4.2 Bilateral Procedures ..................................................................................................... 7
5.5 Member Share – Copay, Coinsurance, and Deductibles ...................................................... 7
   5.5.1 Member Share ............................................................................................................... 7
   5.5.2 Office Member Share .................................................................................................... 7
   5.5.3 Third-Party Premium Payments ................................................................................ 8
5.6 Attachments ......................................................................................................................... 8
5.1 Fee Schedule

5.1.1 Overview

The BCBSNM Maximum Allowable Fee Schedule for PPO/HMO/PAR/POS networks utilizes certain aspects of the Medicare Resource Based Relative Value System (RBRVS) methodology as further described in the reimbursement attachment to your participation agreement with BCBSNM. RBRVS establishes Relative Value Units (RVUs) for most procedure codes based on the resources, knowledge, and cost needed to provide the service. It also provides a consistent method of determining the price for each code, relative to other codes. In most cases, to determine a fee for a procedure code, multiply the total RVU for the code by the applicable Conversion Factor (CF) in your participation agreement with BCBSNM (e.g., RVU of 1.234 x a CF of $39.36 = $48.57). BCBSNM may update RVUs based on and subsequent to changes made by CMS. BCBSNM may also make certain adjustments to RVUs such as, but not limited to, New Mexico’s Geographic Practice Cost Indices (GPCIs) and Site of Service (SOS).

The BCBSNM Maximum Allowable Fee Schedules for Blue Preferred, Blue Advantage and Blue Community list prices for Covered Services furnished to Members with health plans supported by those networks.

5.1.2 Fee Schedule Requests

Providers can obtain an entire fee schedule or request fee information for specific codes by filling out a Fee Schedule Request Form (and related Confidentiality Agreement) available on the bcbsnm.com provider website under Forms.

Medicare Relative Values and fees are available on the Centers for Medicare & Medicaid Services (CMS) website, at cms.hhs.gov/home/medicare.asp. The RVUs on the CMS website are not adjusted for New Mexico GPCIs.

**Note:** The BCBSNM fee schedule is not a guarantee of payment. Services represented are subject to provisions of the health plan including, but not limited to: membership, eligibility, premium payment, claim payment logic, provider contract terms and conditions, applicable medical policy, benefits limitations and exclusions, bundling logic, and licensing scope of practice limitations. Maximum allowable may change from time to time subject to notice requirements of applicable law and regulations and prevailing provider agreement. CPT codes are copyright by the American Medical Association. Additional provider information is available on the website at [www.bcbsnm.com](http://www.bcbsnm.com).

5.1.3 Reimbursement for Specific Services

**Durable medical equipment (DME) services** - Fees for most DME services are updated annually based on a percentage of the Medicare flat fees, available on the CMS website. Correct pricing for DME equipment requires use of modifiers for rental (RR), used purchase (UE), new purchase (NU), and less than a full month rental (KR).
Clinical laboratory services - Fees for most clinical laboratory services are updated annually based on a percentage of the Medicare flat fees, available on the CMS website.

Immunizations or injectable drugs (J-codes) - Fees for these services are established based on the BCBSNM Average Sale Price (ASP), which is based on the ASP published by CMS and are the same for all four networks (PAR, PPO, HMO, and POS).

- **NOTE:** Pursuant to the New Mexico Vaccine Purchasing Act, NMSA 1978, Section 24-5A-1, et seq. (2015), and Section 7.5.4.9 NMAC (2015), to avoid duplication of payment, providers must not bill for the cost of, and shall not be reimbursed by BCBSNM, for vaccines purchased by the New Mexico Department of Health and administered to insured children covered by a health plan underwritten by BCBSNM. Providers may, however, submit claims to BCBSNM for the administration of the vaccines using the appropriate CPT code(s), reimbursement for which, if any, will be determined by the provider’s participation agreement with BCBSNM and all other conditions of coverage. Pursuant to notice from BCBSNM, if any, Participating Providers shall also furnish to BCBSNM any additional documentation or information, including claims based, necessary for BCBSNM to comply with the Vaccine Purchasing Act and regulations promulgated thereunder.

The allowable amount is based on the NDC and/or Generic Product Identifier (GPI) when the provider contract stipulates to do so.

Refer to [Section 8](#), Claims Submission for billing drug codes.
5.2 Anesthesia Guidelines

5.2.1 Overview

Anesthesia procedures are generally reimbursed according to time units for the specific procedure, plus base units multiplied by the anesthesia conversion factor for that provider. BCBSNM defines anesthesia time units two ways:

Surgical procedures: One unit for each 15-minute increment, or a part of.

Labor and delivery codes: Vaginal delivery codes are reimbursed one unit per hour up to 16 hours. C-section delivery codes are reimbursed in 15-minute increments.

Base units are the relative value unit assigned by the American Society of Anesthesiologists (ASA).

An example of this equation is as follows: {(ASA base units) + (time units)} x Anesthesia Conversion Factor = Allowable.

5.2.2 Consultative, Diagnostic, and Therapeutic Services

Consultative, diagnostic, and therapeutic services, as recognized by the Current Procedural Terminology (CPT) book, include:

- Evaluation and management services
- Pain management and nerve blocks
- Other codes

These services are reimbursed according to the BCBSNM medical and surgical conversion factors multiplied by the base unit value (which could be the RVU or the ASA unit value depending on the provider contract) for that specific procedure code.

5.2.3 Physical Status Modifiers and Qualifying Circumstances

Physical Status Modifiers (P3, P4, and P5) and Qualifying Circumstances codes (99100, 99116, 99135, and 99140) will be considered if they are billed with the appropriate codes
### 5.3 Pricing Modifiers

Some HCPCS and CPT modifiers have potential pricing impacts. Modifiers can affect pricing in multiple ways. The table below identifies commonly used modifiers and the potential pricing impacts. Actual fees are determined by contract criteria for any specific provider.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Potential Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>Professional Interpretive Service – Used when the procedure has a technical and professional split between the full service RVU for professional only services, when appropriate</td>
<td></td>
</tr>
<tr>
<td>TC</td>
<td>Technical Component – Used when the procedure has a technical and professional split between the full service RVU for technical only services, when appropriate</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Bilateral Surgery – Used when the description of the CPT or HCPCS codes doesn’t already indicate a bilateral procedure 150% of fee</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>Multiple Surgery 50% of fee</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>Service or procedure that is partially reduced or eliminated 50% of fee</td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>Discontinued Procedure 50% of fee</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>Surgical Care Only 75% of fee</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Post-operative Management Only 12.5% of fee</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>Pre-operative Management Only 12.5% of fee</td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>Co-surgery 62.5% of fee</td>
<td></td>
</tr>
<tr>
<td>78</td>
<td>Return to OP Room 75% of fee</td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>Assistant Surgeon 20% of fee</td>
<td></td>
</tr>
<tr>
<td>81</td>
<td>Minimum Assistant Surgeon 20% of fee</td>
<td></td>
</tr>
<tr>
<td>82</td>
<td>Assistant Surgeon when qualified resident surgeon not available 20% of fee</td>
<td></td>
</tr>
<tr>
<td>AD</td>
<td>Medical Supervision, &gt; four Anesthesia procedures 63% of fee</td>
<td></td>
</tr>
<tr>
<td>AS</td>
<td>Assistant at surgery service 12% of fee</td>
<td></td>
</tr>
<tr>
<td>P3</td>
<td>Patient with severe systemic disease +1 Anes. unit</td>
<td></td>
</tr>
<tr>
<td>P4</td>
<td>Patient with severe systemic disease – life-threatening +2 Anes. unit</td>
<td></td>
</tr>
<tr>
<td>P5</td>
<td>Patient not expected to survive without operation +3 Anes. unit</td>
<td></td>
</tr>
<tr>
<td>NU</td>
<td>New DME being purchased Purchase allowable for new equipment (1)</td>
<td></td>
</tr>
<tr>
<td>QK</td>
<td>Medically directed two to four concurrent anesthesia procedures 63% of fee</td>
<td></td>
</tr>
<tr>
<td>QX</td>
<td>CRNA service with MD medical direction 37% of fee</td>
<td></td>
</tr>
<tr>
<td>QY</td>
<td>Medically directed CRNA 63% of fee</td>
<td></td>
</tr>
<tr>
<td>RR</td>
<td>Rental (DME) Rental allowable/Monthly (2)</td>
<td></td>
</tr>
<tr>
<td>KR</td>
<td>Rental (DME) Rental allowable/Daily – required for rentals of less than a full month (3)</td>
<td></td>
</tr>
<tr>
<td>UE</td>
<td>Used DME Purchase allowable for used equipment (1)</td>
<td></td>
</tr>
</tbody>
</table>

(1) Purchase of equipment can be paid only one time.
(2) Monthly rental is for a full month, regardless of the number of actual days in the month being billed.
(3) Daily rental is calculated based on 1/30th of the monthly rental x the # of days the equipment was in the patient’s home. The same calculation applies regardless of the actual number of days in the month being billed.
5.4 Professional Multiple Surgery Guidelines

5.4.1 Multiple Procedures, Same Operative Session

Standard consideration for multiple procedures (modifier 51) performed during the same operative session allows for an eligible amount of 100% of the provider’s allowance for the procedure with highest allowance. Secondary and tertiary procedures appropriate for application of multiple surgery pricing (see note below) are allowed at 50% of the allowance for the procedure.

5.4.2 Bilateral Procedures

Standard consideration for bilateral procedures (modifier 50) allows for an eligible amount of 150% of the provider’s allowance for both sides (100% for the first side and 50% for the second). The multiple surgery guidelines apply when multiple related and unrelated services are billed during the same operative session in addition to bilateral procedures.

**Important Note:** Surgical procedures defined by the American Medical Association as Modifier 51 exempt or an “add-on” code are not subject to the above Multiple Surgery Pricing Guidelines.

5.5 Member Share – Copay, Coinsurance, and Deductibles

5.5.1 Member Share

Providers contracted with BCBSNM must collect member share. It should be collected at the time the service is provided. Check the member’s ID card for the proper member share amount to collect. If you are unaware of the status of the deductible, collect 10 percent of the service being provided. You may have to refund the member when the Provider Claims Summary arrives, and you can determine the exact member share. Member share is inclusive of State gross receipts tax, if applicable.

5.5.2 Office Member Share

An office member share is usually required for all office visits for which your office would ordinarily generate a charge, including blood pressure checks, educational sessions with a nutritionist, physical therapy, etc. If a charge is not generated for a visit, no member share should be collected.
Do not collect an office member share for non-surgical diagnostic procedures when there are no other office visit charges associated with those procedures. This includes lab, X-rays, mammograms, audiograms, and EKGs.

5.5.3 Third-Party Premium Payments

Premium payments for individual plans are a personal expense to be paid for directly by individual and family plan subscribers. In compliance with Federal guidance, BCBSNM will accept third-party payment for premium directly from the following entities:

(1) the Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
(2) Indian tribes, tribal organizations or urban Indian organizations; and (3) state and federal Government programs.

BCBSNM may choose, in its sole discretion, to allow payments from not-for-profit foundations, provided those foundations meet nondiscrimination requirements and pay premiums for the full policy year for each of the covered persons at issue. Except as otherwise provided above, third-party entities, including hospitals and other health care providers, shall not pay BCBSNM directly for any or all of an enrollee's premium.

5.6 Attachments

Fee Schedule Request Form