DME Pricing Development and Maintenance Policy

Unless your contract agreement or terms specify otherwise, the following policy applies to BCBSNC providers participating under a **"**Network Participation Agreement-Ancillary**"** contact.

This Pricing Development and Maintenance Policy applies to Blue Cross and Blue Shield of North Carolina's ("BCBSNC's") calculations of contractual allowances ('fees") for services billed on a CMS 1500 or successor claim form. Each uniquely identifiable service is assigned a Service Category, based upon the HCPCS Level I ("CPT") or Level II code. Fee calculations applicable to each Service Category are described below, including the External Pricing Source. BCBSNC will update annually those Service Categories based on Current Year Pricing Source as listed below. The annual updates will be made based on pricing sources in effect on January 1. Fees based on current year Medicare are determined by the first Medicare file published in the Federal Register, post Congressional Review, designated to be effective on January 1. Quarterly updates as indicated below will be made based on pricing source in effect the last month of the preceding quarter. BCBSNC will not adjust pricing once established for the year until the following calendar year.

Reimbursement is based upon the hierarchy listed below. Rates are based on current calendar year and will be updated on an annual basis. The first of the following criteria that can be used to establish a price will be the applicable source:

1. 75% current year CMS NC DMEPOS (Not based upon Competitive Bid Allowance).
2. 75% current year OptumInsight, as licensed by BCBSNC
3. 75% of the following fee: the national 60th percentile of billed charges for the applicable code provided by FAIR Health Benchmarks HCPCS product, as reported through Optum's EncoderPro or through successor product licensed by BCBSNC

If none of the above sources contains a price for the applicable code, the contractual allowance for reimbursement will be based on:

4. Individual Consideration or if no price can be determined;
5. 75% of your Reasonable Charge

Fee Determination Based on a Percentage of Your Reasonable Charge

- When application of the hierarchy and criteria for the determination of contractual allowances results in a fee for a given service based upon a percentage of your charge, you are obligated to ensure that: (1) all charges billed to BCBSNC are reasonable; (2) all charges are consistent with your fiduciary duty to your patient and BCBSNC; (3) no charges are excessive in any respect; and (4) all charges are no greater than the amount regularly charged to the general public, including those persons without health insurance.

Fee Determination Based on Individual Consideration

- If a general code (e.g. A9999 or E1399, misc DME supply) is filed because a code specific to the service or procedure is nonexistent, or if a pricing source in the pricing hierarchy is for any reason otherwise unavailable, BCBSNC will assign a fee to the service which will be a reasonable fee established by BCBSNC using a methodology chosen by BCBSNC in its reasonable discretion, utilizing one or more available sources. These sources may include, but are not limited to, reimbursement levels for similar or analogous equipment, national average pricing, or other available pricing information.

- Some codes that are listed as specific codes in the CPT/HCPCS manuals relate to services that can have wide variation in the type and/or level of service provided. These codes will be treated by BCBSNC in the same manner as general codes, as described in the above paragraph.

- DMEPOS Services that are filed using general or unlisted codes must include the applicable manufacturer's invoice, and will be priced at 10% above your acquisition cost supported by your invoice and any other pertinent pricing-related information. BCBSNC may reimburse a higher price for customized items, as specifically agreed by BCBSNC in writing. BCBSNC will not allow more than 75% of your charge for these services.

- If a general or unlisted code is filed despite the existence of a code specific to the service or procedure, BCBSNC will assign the more specific code to determine the fee under BCBSNC's applicable reimbursement policies.

- BCBSNC's assignment of a fee for a given general or unlisted code does not preclude BCBSNC from assigning a different fee for a subsequent service or procedure under the same code. BCBSNC's determination of a fee for a service billed for a given general or unlisted code may vary from a previously determined fee based on new analysis, or new or additional information that subsequently becomes available regarding the service in question or other similar services.

Additional Fee Determinations

- Fees based on current year Medicare are determined by the first Medicare file published in the Federal Register, post Congressional Review, designated to be effective on January 1. BCBSNC will make such fee adjustment within 30 days of such first published Medicare file. BCBSNC will apply the adjusted fees to claims paid after such date of BCBSNC adjustment, with no obligation to adjust claims already paid. Additionally, BCBSNC has no obligation to adjust rates due to new rates or rate adjustments published by CMS after such first published Medicare file.

- BCBSNC reimburses the lesser of your charge or the applicable fee in accordance with your contract and this Pricing Policy.

- Nothing in this Pricing Policy will obligate BCBSNC to make payment on a claim for a service or supply that is not covered under the terms of the applicable benefit plan. Furthermore, the determination of a code-specific fee does not guarantee payment for the service.

- In the event that any External Pricing Source reference listed below changes (e.g. a new Medicare intermediary is selected), references in this Pricing Policy will be deemed to refer to the superseding source.

- Fees for services represented by CPT/HCPCS codes that are introduced after the effective date of this Pricing Policy will be determined based upon the hierarchy and criteria applicable to the Service Category of the new code.

External Pricing Sources

All references in this Pricing Policy to External Pricing Sources refer to the following:

- NC DMEPOS fee schedule
  - http://www.cms.hhs.gov/DMEPOSFeeSched/

- OptumInsight *The Essential RBRVS*
  - http://www.optuminsight.com

- FairHealth, Inc
  http://www.fairhealthus.org/products/data-products

Other General / Billing DME Requirements

General Requirements

- Always refer to and follow the policies and procedures that are documented in the appropriate DME section(s) of the Provider BlueBook.

Billing

Provider agrees to:

- Bill using the CMS-1500 claim form.
- Use your appropriate National Provider Identifier.
- Bill maintenance and repair modifier codes first after the procedure code.
- Submit claims with miscellaneous codes (ie: A9999, E1399) with a complete description of the item, a factory invoice and documentation of medical necessity with the *initial* claim for each patient.
- Use a "Miscellaneous" code only if no suitable HCPCS billing code is available and appropriate documentation is included.
- Submit all claims for repairs with a complete description of services provided.
- Bill your typical retail charges.
- Comply with specific billing requirements related to HCPCS E0784 (External ambulatory infusion pump, insulin).

Payment - Rentals

- Rental prices include all equipment, accessories, delivery, shipping & handling, labor, set-up, visits, education, maintenance, repairs and replacement parts of DME on a monthly basis.
- Always include rental modifier code on rental claim forms.
- Bill each thirty days of rental as one unit. Rental claims that are ongoing will only be processed at the end of each month of service.
- Items filed without the rental modifier and rental dates are assumed to be purchases and are paid accordingly.

Payment - Repairs

- Use standard HCPC codes when submitting maintenance / repair claims.
- Warranty repairs are not eligible for reimbursement.
- The labor component of the repair should be billed under the appropriate repair code.
- All replacement parts should be billed separately under the appropriate HCPCS code(s).
- Repairs may only be billed on purchased items.
- Repairs may not be billed on rented equipment.
- Submit the complete description of services provided when billing a repair code.
- Bill the repair or maintenance modifier code first after the procedure code, when submitting with other modifier codes.