

Last Review: May 14, 2026
Next Review: May 14, 2028 (or as needed)
Effective Date: August 01, 2026

Billing Guidelines

Providers are expected to submit claims for services rendered using valid code combinations from the Health Insurance Portability and Accountability Act (HIPAA) approved code sets.

Claims submitted shall be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor (UBE), American Medical Association Current Procedural Terminology (CPT®) Assistant, Healthcare Common Procedure Coding System (HCPCS), ICD-10-CM and ICD-10-PCS, National Drug Codes (NDC), Medicare Diagnosis Related Group guidelines (MS-DRG), Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) edits and other CMS guidelines, as well as applicable Vermont law.

Any deviations from these or other industry standards will be specified in the Blue Cross and Blue Shield of Vermont (Blue Cross VT) payment policies.

As required to support the processing of a claim, providers are responsible for submitting accurate documentation of services performed.

Benefit Determination Guidance

It is important to verify benefits **prior** to rendering the service(s). Services specifically excluded from a member's coverage will not be considered or approved for reimbursement.

Services eligible for payment are subject to the applicable member cost sharing, such as co-payment, co-insurance, and deductible.

In certain circumstances, members may be financially responsible for services beyond the benefit provided for eligible services.

Federal Employee Program (FEP): FEP Members' benefits are dictated by the federal government and can be significantly different from benefits covered by other plans in Vermont. For further information, please refer to the [FEP Program Brochures](#), or contact FEP customer service at (800) 328-0365 or fepcustomerservice@bcbsvt.com.

BlueCard Member: A BlueCard Member is an individual who is insured by a Blue Cross plan outside of Vermont. When a BlueCard Member receives care from a provider directly contracted with Blue Cross VT, the member's Blue Plan determines only whether the services rendered to their members are eligible for benefits. The BlueCard Member's Plan must honor Blue Cross VT billing practices, payment policies and allowances and cannot apply its local billing practices to claims rendered in the Blue Cross VT service area, unless that Blue Plan has a direct contractual relationship with the provider (such as in counties contiguous to Vermont).

If a BlueCard Member has Medicare as their primary insurance, Blue Cross VT payment policies do not apply. Contact the members' Blue Plan for details.

Medicare Primary Member: If a member has a Medicare Supplement policy as their primary insurance, Medicare payment guidelines apply, Blue Cross VT payment policies do not apply.

For any product that is secondary to Medicare, other than a Medicare Supplement policy, Blue Cross VT payment policies usually apply.

Eligible Providers

This policy applies to all providers and facilities.

Audit Information

To ensure compliance with Plan guidelines, Blue Cross VT reserves the right to conduct audits on any provider or facility. Blue Cross VT initiates audits through its internal auditing team and through third-party vendors. If an audit identifies instances of non-compliance, Blue Cross VT reserves the right to recover all non-compliant payments. To the extent Blue Cross VT seeks to recover interest; it may cross-recover that interest between Blue Cross VT and TVHP. Details about specific audit policies can be found in the Provider Handbook and in individual payment policies.

Document Precedence

This section provides guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

- 1) To the extent that there may be any conflict between a payment policy and the Certificate of Coverage or employer's health plan documents, the Certificate of Coverage or employer's health plan documents language takes precedence.

- 2) To the extent that there may be any conflict between a payment policy and a provider's contract, the provider's contract takes precedence.
- 3) To the extent that there may be any conflict between a payment policy and Blue Cross VT medical policy, the Blue Cross VT medical policy takes precedence.