BlueCross BlueShield of Texas

Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠ Provider Manual – Filing Claims - Billing Requirements

THIS SECTION CONTAINS REQUIRED DISCLOSURES CONCERNING CLAIMS PROCESSING PROCEDURES

Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO, Blue Premier** and **MyBlue Health**. These specific requirements will be noted with the plan/network name. If a plan/network name is not specifically listed or the "**Plan**" is referenced, the information will apply to **all** HMO products.

In this section

The following topics are covered in this section:

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Billing Requirements

In this Section

The following topics are covered in this section:

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Billing Requirements

Billing Requirements Overview

This section provides an overview of Blue Cross and Blue Shield of Texas (BCBSTX) related to coordination of benefits and appropriate claims submission information.

Capitated Medical Group - Important Note

Health care providers who are contracted/affiliated with a capitated Medical Group must contact the Medical Group for instructions regarding referral and prior authorization processes, contracting, and claims-related questions. Additionally, health care providers who are not part of a capitated Medical Group but who provide services to a member whose PCP is contracted/affiliated with a capitated Medical Group must also contact the applicable Medical Group for instructions. Health care providers who are contracted/affiliated with a capitated Medical Group are subject to that entity's procedures and requirements for the Plan's provider complaint resolution.

Coordination of Benefits and Patient's Share

Members occasionally have two or more benefit policies. When they do, the insurance carriers take this into consideration and this is known as Coordination of Benefits (COB).

This information is meant to assist health providers in understanding the coordination of benefits clause from the contracting perspective.

This information applies to the member's health benefit policies issued by BCBSTX. Please note: some Administrative Services Only (ASO) self-funded groups may elect not to follow the general Coordination of Benefits rules of BCBSTX.

When the member's health benefits policy is issued by another Blues plan, also known as the HOME plan, the Coordination of Benefits provision is administered by that HOME plan, not BCBSTX. Therefore, the member's HOME plan health benefits policy will control how Coordination of Benefits is applied to that member.

What does this mean for you?

Once the claim has been processed by BCBSTX as the secondary carrier, the only patient share amount that may be collected from the member is the amount showing on the BCBSTX Provider Claim Summary.

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Billing Requirements

Coordination of Benefits and Patient's Share (cont.)

The primary carrier does not take into account the member's secondary coverage. This means that once the claim is processed as secondary by BCBSTX, any patient share amount shown to be owed on the primary carrier's explanation of benefits is no longer collectible.

If you have questions regarding a specific claim, please contact the **Plan**'s Provider Customer Service:

Blue Essentials: 1–877-299-2377
Blue Advantage HMO: 1-800-451-0287
Blue Premier: 1-800-876-2583
MyBlue Health: 1-800-451-0287

Coordination of Benefits/ Subrogation

The **Plans** attempt to coordinate benefits whenever possible, including follow-up on potential subrogation cases in order to help reduce overall medical costs. Other coverage information may be obtained from a variety of sources, including the health care provider. Quite often health care providers treating a member are the first to learn about the potential for other coverage. Information such as motor vehicle accidents, work-related injuries, slips/falls, etc. should be communicated to the **Plan** for further investigation. In addition, each health care provider shall cooperate with the **Plan** for the proper coordination of benefits involving covered services and in the collection of third-party payments including workers' compensation, third-party liens and other third-party liability. The **Plan's** contracted health care providers agreed to file claims and encounter information with the **Plan** even if the health care provider believes or knows there is a third-party liability.

To contact the Plans regarding:

- Coordination of benefits, call **1-888-588-4203**
- Subrogation cases, call **1-800-582-6418**

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Billing Requirements

Correct Coding

Use the appropriate Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and International Classification of Diseases (ICD) codes on all claims.

Splitting Charges on Claims

When billing for services provided, codes should be selected that best represent the services furnished. In general, all services provided on the same day should be billed under one electronic submission or when required to bill on paper, utilize one CMS-1500 claim form when possible. When more than six services are provided, multiple CMS-1500 claim forms may be necessary.

Services Rendered Directly By a Health Care Provider

If services are rendered directly by the health care provider, the services must be billed by that health care provider. However, if the health care provider does not directly perform the service and the service is rendered by another provider, only the rendering provider can bill for those services.

Notes:

1. This does not apply to services provided by an employee of a Plan health care provider, e.g. Physician Assistant, Surgical Assistant, Advanced Practice Nurse, Clinical Nurse Specialist, Certified Nurse Midwife and Registered Nurse First Assistant, who is under the direct supervision of the billing health care provider.
2. The following modifiers should be used by the supervising physician when he/she is billing for services rendered by a Physician Assistant (PA), Advanced Practice Nurse (APN) or Registered Nurse First Assistant (RNFA):

AS Modifier:

- Append the AS modifier when non-physician practitioners (PA, APN, CRNFA or LSA) are assisting surgeons as a surgical assistant.
- Append the modifier when the supervising physician is billing on behalf of a PA, APN, or CRNFA or LSA including that provider's National Provider Identification (NPI) number.
- Append modifier to PA, APN, CRNFA or LSA claim submissions when billing with their own NPI.

SA Modifier

- Append modifier to supervising physician claim submissions when billing on behalf of a PA, APN, or CRNFA for non-surgical services.
- Append modifier to PA's, APN's, or CRNFA's claim submission when billing with their own NPI number for assisting with any other non-surgical procedures.
- Claims will be processed based on the provider's contracting status.

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Billing Requirements

Surgical Procedures Performed in the Physician's or Professional Provider's Office

When performing surgical procedures in a non-facility setting, the physician or professional provider's reimbursement covers the services, equipment, and some of the supplies needed to perform the surgical procedure when a member receives these services in the physician's or professional provider's office. Reimbursement will be allowed for some supplies billed in conjunction with a surgical procedure performed in the physician's or professional provider's office. To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSTX's code- auditing software. Refer to the BCBSTX provider website at bcbstx.com/provider for additional information on gaining access to C3.

Please note the physician and professional provider's reimbursement includes surgical equipment that may be owned or supplied by an outside surgical equipment or Durable Medical Equipment (DME) vendor. Claims from the surgical equipment or DME vendor will be denied based on the fact that the global physician/provider reimbursement includes staff and equipment.

Contracted Health Care Providers Must File Claims

As a reminder, health care providers must file claims for any covered services rendered to a patient enrolled in a BCBSTX health plan. You may collect the full amounts of the member's cost share such as deductible, coinsurance or copayment due and then file the claim with BCBSTX. Arrangements to offer cash discounts to an enrollee in lieu of filing claims with BCBSTX violate the requirements of your health care provider's contract with BCBSTX.

Notwithstanding the foregoing, a provision of the American Recovery and Reinvestment Act changed the Health Insurance Portability and Accountability Act (HIPAA) to add a requirement that if a patient self-pays for a service in full and directs a health care providers to not file a claim with the patient's insurer, the health care providers must comply with that directive and may not file the claim in question. In such an event, you must comply with HIPAA and not file the claim to BCBSTX.

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Billing Requirements

Billing for Non-Covered Services

If the **Plan** determines in advance that a proposed service is not a covered service, a health care provider must inform the Member in writing in advance of the service rendered. The member must acknowledge this disclosure in writing and agree to accept the stated service as a non-covered service billable directly to the member.

To clarify what the above means - if you contact the **member's Plan** and find out that a proposed service is not a covered service - you have the responsibility to pass this along to your patient (our member). This disclosure protects both you and the member. The member is responsible for payment to you of the non-covered service if the member elects to receive the service and has acknowledged the disclosure in writing.

Please note that services denied by the **Plan** due to bundling or other claim edits may not be billed to member even if the Member has agreed in writing to be responsible for such services. Such services **are** covered services but are **not payable services** according to the **Plan** claim edits.

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Billing Requirements

CPT Modifier 50 Bilateral Procedures - Professional Claims Only

Modifier 50 is used to report bilateral procedures that are performed during the same operative session by the same physician/professional provider in either separate operative areas (e.g. hands, feet, legs, arms, ears), or one (same) operative area (e.g. nose, eyes, breasts).

The current coding manual states that the intent of this modifier is to be appended to the appropriate unilateral procedure code as a one-line entry on the claim form indicating the procedure was performed bilaterally (two times).

An example of the appropriate use of Modifier 50:

Procedure Code	Billed Amount	Units/Days
64470-50	$####.##	1

When using Modifier 50 to indicate a procedure was performed bilaterally, the modifiers LT (Left) and RT (Right) should not be billed on the same service line. Modifiers LT or RT should be used to identify which one of the paired organs were operated on. Billing procedures as two lines of service using the left (LT) and right (RT) modifiers are not the same as identifying the procedure with Modifier 50. Modifier 50 is the coding practice of choice when reporting bilateral procedures. When determining reimbursement, the BCBSTX Multiple Surgery Pricing Guidelines apply. These guidelines are located on our located on our provider website under **Standards and Requirements** then General Reimbursement Information and then go to **Multiple Surgery - Prof.**

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Billing Requirements

Proper Speech Therapy Billing	CPT codes 92507 and 92508 are defined as "treatment of speech, language, voice, communication and/or auditory processing disorder; individual" in the CPT manual. Codes 92507 and 92508 are not considered time-based codes and should be reported only one time per session; in other words, the codes are reported without regard to the length of time spent with the patient performing the service. Because the code descriptor does not indicate time as a component for determining the use of the codes, you need not report increments of time (e.g., each 15 minutes). Only one unit should be reported for code 92507 and 92508 per date of service. Blue Cross and Blue Shield of Texas (BCBSTX) adheres to CPT guidelines for the proper usage of these CPT codes. **Note:** Unless there are extenuating circumstances documented in your office notes — for example, multiple visits on the same day — we will only allow one unit per date of service for these codes.
Care Coordination Services	BCBSTX recognizes the following Category I CPT codes for billing care coordination services: 99487, 99488 and 99489 BCBSTX reimbursement will be subject to the maximum benefit limit specified in the member's benefit plan.

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Billing Requirements

National Drug Code (NDC) Billing Guidelines for Professional Claims

Blue Cross and Blue Shield of Texas (BCBSTX) requests the use of National Drug Codes (NDCs) and related information when drugs are billed on professional/ancillary electronic (ANSI 837P) and paper (CMS-1500) claims.

Where do I find the NDC?

The NDC is usually found on the drug label or medication's outer packaging. If the medication comes in a box with multiple vials, using the NDC on the box (outer packaging) is recommended. The number on the packaging may be less than 11 digits. An asterisk may appear as a placeholder for any leading zeros. The container label also displays information for the unit of measure for that drug. Listed below are the preferred NDC units of measure and their descriptions:

- **UN** (Unit) – Powder for injection (needs to be reconstituted), pellet, kit, patch, tablet, device
- **ML** (Milliliter) – Liquid, solution, or suspension
- **GR** (Gram) – Ointments, creams, inhalers, or bulk powder in a jar
- **F2** (International Unit) – Products described as IU/vial, or micrograms

How do I submit the NDC on my claim?

Here are some quick tips and general guidelines to assist you with proper submission of valid NDCs and related information on electronic and paper professional claims:

- The NDC must be submitted along with the applicable Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®) code(s) and the number of HCPCS/CPT units.
- The NDC must follow the 5digit4digit2digit format (11-digit billing format, with no spaces, hyphens or special characters). If the NDC on the package label is less than 11 digits, a leading zero must be added to the appropriate segment to create a 5-4-2 configuration.
- The NDC must be active for the date of service.
- Also include the **NDC qualifier, number of NDC units,* NDC unit of measure**. [Note: BCBSTX allows up to three decimals in the NDC Units (quantity or number of units) field. If you do not include appropriate decimals in the NDC units field, you could be underpaid. As a reminder, you also must include your billable charge

ELECTRONIC CLAIM GUIDELINES (ANSI 837P)

Field Name	Field Description	Loop ID	Segment
Product ID Qualifier	Enter **N4** in this field.	2410	LIN02
National Drug Code	Enter the 11-digit NDC billing format assigned to the drug administered.	2410	LIN03
National Drug Unit Count	Enter the quantity (number of NDC units)	2410	CTP04
Unit or Basis for Measurement	Enter the NDC unit of measure for the prescription drug given (**UN**, **ML**, **GR**, or **F2**)	2410	CTP05

Note: The total charge amount for each line of service also must be included for the Monetary Amount in loop OD 2400, Segment SV102.

PAPER CLAIM GUIDELINES (CMS-1500)

In the *shaded portion* of the line-item field 24A-24G on the CMS-1500, enter the qualifier **N4 (left-justified), immediately followed by** the NDC. Next, enter one space for separation, then enter the appropriate qualifier for the correct dispensing unit of measure (**UN**, **ML**, **GR,** or **F2**), followed by the quantity (number of NDC units up to three decimal places), as indicated in the example below.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N400409476586 ML120 0.14950													N		12345678901
01	01	13	01	01	13	11		J0744		1	17.94	6	N	NPI	123456789

The standard NDC Reimbursement Schedule is available in the Standards and Requirements/General Reimbursement information section of the BCBSTX Provider website at www.bcbstx.com/provider. For additional information on NDC billing and reimbursement, view answers to Frequently Asked Questions.

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Billing Requirements

Billing & Documentation Information & Requirements

Permissible Billing

BCBSTX does not permit **pass-through billing, splitting all-inclusive bills, under-arrangement billing**, and any billing practices where a provider or entity submits claims by or for another provider not otherwise provided for in the provider's agreement or in this policy.

Pass-Through Billing

Pass-through billing occurs when the ordering health care provider requests and bills for a service, but the service is not performed by the ordering health care provider.

The performing health care provider is required to bill for the services they render unless otherwise approved by BCBSTX.

BCBSTX does not consider the following scenarios to be pass-through billing:

- The service of the performing health care provider is performed at the place of service of the ordering physician or professional provider and billed by the ordering physician or professional provider;
- The service is provided by an employee of a health care provider (i.e., physician assistant, surgical assistant, advanced nurse practitioner, clinical nurse specialist, certified nurse midwife or registered first assistant who is under the direct supervision of the ordering physician or professional provider); and the service is billed by the ordering physician or professional provider.
- The service is billed by the ordering physician or professional provider

Refer to Services **Rendered Directly By a Health Care Provider** section above regarding modifiers used by the supervising physician when billing for services rendered by a Physician Assistant (PA), Advanced Practice Nurse (APN) or Registered Nurse First Assistant. (RNFA).

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Billing Requirements

Billing & Documentation Information & Requirements, cont.

Under - Arrangement Billing

"**Under-arrangement**" billing and other similar billing or service arrangements are not permitted by BCBSTX. "Under-arrangement" billing refers to situations where services are performed by a health care provider but the services are billed under the contract of another health care provider, rather than under the contract of the health care provider that performed the services.

All-Inclusive Billing

Any testing performed on patients treated by a health care provider that is compensated on an all-inclusive rate should not be billed separately by the facility or any other provider. The testing is a part of the per diem or outpatient rates paid to a facility for such services. The health care provider may, at their discretion, use other providers to provide services included in their all-inclusive rate, but remain responsible for costs and liabilities of those services, which shall be paid by the facility and not billed directly to BCBSTX.

For all-inclusive billing, all testing and services that share the same date of service for a patient must be billed on one claim. Split billing is a violation of network participating provider agreements.

Other Requirements and Monitoring

CLIA Certification Requirement

Facilities and providers who perform laboratory testing on human specimens for health assessment or the diagnosis, prevention, or treatment of disease are regulated under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Therefore, any provider who performs laboratory testing, including urine drug tests, must possess a valid a CLIA certificate for the type of testing performed.

Review of Codes

BCBSTX may monitor the manner in which test codes are billed, including frequency of testing. Abusive billing, insufficient or lack of documentation to support the billing, including a lack of appropriate orders, may result in action taken against the provider's network participation and/or 100% review of medical records for such claims submitted.

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Billing Requirements

Other Requirements and Monitoring

Limitations and Conditions

Reimbursement is subject to:

- Medical record documentation, including appropriately documented orders
- Correct CPT/HCPCS coding
- Member Benefit and Eligibility
- Applicable BCBS Medical Policy(-ies)

Obligation to Notify BCBSTX of Certain Changes

Health care providers are required to notify BCBSTX of material changes that impact their contract with BCBSTX including the following:

- Change in ownership
- Acquisitions
- Change of billing address
- Change in the billing information
- Divestitures

Assignment

As a reminder, no part of the contract with BCBSTX may be assigned or delegated by a health care provider without the express written consent of both BCBSTX and the contracted provider.

Fraudulent Billing

The **Plan** considers fraudulent billing to include, but not be limited to, the following:

1. deliberate misrepresentation of the service provided in order to receive payment;
2. deliberately billing in a manner which results in reimbursement greater than what would have been received if the claim were filed in accordance with the **Plan** billing policies and guidelines; and/or
3. billing for services which were not rendered.

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Billing Requirements

Providers with Multiple Specialties

If you have obtained a unique Organization (Type 2) National Provider Identifier (NPI) number for each specialty, you should bill with the appropriate Individual (Type 1) and Organization (Type 2) NPI number combination accordingly.

In the absence of a unique Organization (Type 2) NPI number for each specialty, you are strongly encouraged to include the applicable taxonomy code* in your claims submission. Taxonomy codes play a critical role in the claims payment process for providers practicing in more than one specialty. Electronic claims transactions accommodate the entry of taxonomy codes and will assist BCBSTX in selecting the appropriate provider record during the claims adjudication process. For assistance in billing the taxonomy code in claim transactions, refer to your practice management software and/or clearinghouse guides.

* *The health care provider taxonomy code set is a comprehensive listing of unique 10-character alphanumeric codes. The code set is structured into three levels—provider type, classification, andarea of specialization—to enable individual, group, or institutional providers to clearly identify their specialty category or categories in HIPAA transactions. The entire code set can be found on the Washington Publishing Company (WPC) website. The health care provider taxonomy code set levels are organized to allow for drilling down to a provider's most specific level of specialization.*