Blue Choice PPO℠ and Blue High Performance Network® (Blue HPN)® Provider Manual – Filing Claims - Prompt Pay

Important note:

Throughout this provider manual there will be instances when there are references unique to Blue Choice PPO, Blue High Performance Network, Blue Edge, EPO and the Federal Employee Program These specific requirements will be noted with the plan/network name. If a Plan/network name is not specifically listed or "Plan" is referenced, the information will apply to all PPO products.

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Prompt Pay

Blue Cross and Blue Shield of Texas (BCBSTX) complies with the Texas Prompt Pay Act. The Prompt Pay Act requires insurance carriers to pay clean claims that are subject to the Act's requirements within certain specified statutory payment periods. Insurance carriers that do not comply with the Prompt Pay Act's standards may owe statutory penalties to the provider.

Prompt Pay Legislation - Penalty

Providers are eligible for statutory prompt pay penalties under the Texas Prompt Pay Act only when certain requirements are met, including:

- A claim is made for a member of a plan that is fully insured by BCBSTX
- The patient's insurance plan is regulated by the Texas Department of Insurance (TDI);
- The claim is submitted to BCBSTX as a clean claim;
- The provider files the claim by the statutory filing deadline;
- The provider is a contracting preferred provider, and
- The services billed on the claim are payable.

BCBSTX proactively monitors the timeliness of its payments for eligible claims and issues penalties to providers when it determines penalties are owed. If you believe statutory penalties are due and have not received a penalty payment from BCBSTX, you may request a review of penalty eligibility by contacting BCBSTX Provider Customer Service at **1-800-451-0287**.

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Prompt Pay Legislation - Definition of a Clean Claim

To be eligible for Prompt Pay penalties, providers must submit a clean claim. A clean claim includes all the data elements specified by the TDI in prompt pay rules or applicable electronic standards. Each specified data element must be legible, accurate, and complete.

For non-electronic submissions by institutional providers, a claim should be submitted using the Centers for Medicare and Medicaid Services (CMS) Form UB-04.[1] The UB-04 claim form must include all the required data elements set forth in TDI rules,[2] including, if applicable, the amount paid by the primary plan.[3]

For non- electronic submissions by professional providers, a claim shall be submitted on a CMS Form 1500) claim form.

Electronic claims by professional or institutional providers must be submitted using the ASC X12N 837 format to be considered a clean claim. Providers must submit the claim in compliance with the Federal Health Insurance Portability and Accountability Act (HIPAA) requirements related to electronic health care claims, including applicable implementation guidelines, companion guides, and trading partner agreements.[4]

A claim that does not comply with the applicable standard is a deficient claim and will not be penalty eligible.[5] When BCBSTX is unable to process a deficient claim, it will notify the provider of the deficiency and request the correct data element.

At times, deficient claims contain sufficient information for BCBSTX's adjudication and payment. Rather than requiring the provider to correct the deficiency before payment is issued, BCBSTX considers it in the best interest of providers to pay deficient claims as soon as possible. However, because deficient claims are not clean claims, they are not eligible for penalties even if BCBSTX pays the claim outside of the applicable payment period.[6]

1 Ex. C, Tex. Ins. Code § 1301.131(b).
2 Ex. B, 28 Tex. Admin. Code § 21.2803(b)(3).
3 Ex, B, 28 Tex. Admin. Code § 21.2803(d)(1).
4 Ex. B, 28 Tex. Admin. Code § 21.2803(e).
5 Ex. D, 28 Tex. Admin. Code § 21.2802(10).
6 Ex. E, Report on the Activities of the Technical Advisory Committee on Claims Processing (Sep. 2004), at pp. 6-7.

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Prompt Pay Legislation - Statutory Claim Payment Periods

When a contracting provider submits a clean claim that meets all the requirements for Texas Prompt Pay Act coverage, the insurer must pay the claim within 30 days if it was submitted in electronic format and within 45 days if it was submitted in non-electronic format or as defined by the Texas Department of Insurance.[7] If a claim is deficient, the statutory period does not commence unless and until the provider corrects the unclean data element(s). The payment period for clean corrected claims is determined by the format of the corrected submission, without regard to the manner in which the original claim was received.

BCBSTX may extend the applicable statutory payment by requesting additional information from the treating provider within thirty days of receiving a clean claim.[8] Such a request suspends the payment period until the requested response is received.[9] BCBSTX must then pay any eligible charges within the longer of (1) fifteen days, or (2) the number of days remaining in the original payment period at the time the request was sent.[10]

Prompt Pay Legislation - Statutory Penalty Amounts

There are three (3) tiers of penalty calculation under the Texas Prompt Pay Act, depending on when the claim was paid. For claims submitted by institutional providers, half of the amount calculated in each tier is owed to the provider and the other half is owed to the Texas Department of Insurance.[11]

Tier 1: For payments 1 - 45 days late, the total penalty is equal to 50 percent of the difference between the billed charges and the contracted rate.[12]

Tier 2: For payments 46 – 90 days late, the total penalty is equal to 100 percent of the difference between the billed charges and the contracted rate.[13]

Tier 3: For payments more than 90 days late, the total penalty is equal to the Tier 2 amount plus 18% annual interest on that amount, accruing from the date payment was due to the date the claim and penalty are paid in full.[14]

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7 Ex. F, Tex. Ins. Code § 1301.103.
8 Ex. G, Tex. Ins. Code § 1301.1054(a)
9 Ex. G, Tex. Ins. Code § 1301.1054(b).
10 Ex. G, Tex. Ins. Code § 1301.1054(b).
11 Ex. H, Tex. Ins. Code § 1301.137(l).
12 Ex. H, Tex. Ins. Code § 1301.137(a).
13 Ex. H, Tex. Ins. Code § 1301.137(b).
14 Ex. H, Tex. Ins. Code § 1301.137(c).

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Prompt Pay Legislation - Coordination of Benefits

Coordination of benefits is necessary when more than one plan is responsible for claim payment. Claims that involve coordination of benefits are subject to special rules under the Texas Prompt Pay Act.

When providers are aware of multiple plans potentially involved in claim payment, information related to all applicable plans must be submitted for the claim to be clean. The Provider must submit the claim first to the primary plan and then to any secondary or tertiary plans. The order of payer responsibility is determined by TDI guidelines, which have adopted the uniform rules of the National Association of Insurance Commissioners (NAIC).[15]

When BCBSTX is the secondary payer of a claim submitted in non-electronic format, the amount paid by the primary plan is a required data element and must be submitted in field 54 for the claim to be clean.[16] Thus, the applicable statutory payment period for a secondary plan does not begin unless and until it receives the primary plan's adjudication information.

If BCBSTX determines that a secondary plan has paid an amount owed by the primary plan in error, it may recover the amount of its overpayment from the primary plan or from the provider if it has already been reimbursed by the primary plan.[17] For purposes of calculating Texas Prompt Pay Act penalties for secondary claims, the contracted rate and billed charges are reduced in proportion to the percentage of the claim owed after the primary plan's payment.[18]

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15 Ex. J. 28 Tex Admin. Code § 3.3507.
16 Ex. B, 28 Tex. Admin. Code § 21.2803(d)(1).
17 Ex. K. K, Tex. Ins. Code § 1301.134(e)-(f).
18 Ex. L, 28 Tex. Admin. Code 21.2815(e).